IN Files

HEALTH CARE FRAUD AND WASTE
(Part 1)

HEARINGS

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES

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CONTENTS

HEALTH CARE FRAUD AND WASTE

THURSDAY, OCTOBER 10, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. John D. Dingell (chairman) presiding.

Mr. DINGELL. The subcommittee will come to order.

In today's hearing, the subcommittee will lay the groundwork for a series of future hearings on the crucially important subject, and that is the problem of enormously expensive waste, fraud, and abuse that does not quite constitute illegality in the health care industry. Pursuant to the responsibilities of this committee under Rules X and XI of the Rules of the U.S. House of Representatives and in furtherance of the jurisdiction of the committee relative to public health, we will be attempting to determine the size of the bill the Nation is paying for health care and for fraud, also who is committing fraud, how good a job needs to be done, and how good a job we are doing at finding and stopping that fraud. We also will be inquiring into what success we are having in recouping the moneys that we have lost. We will look into the additional hidden price that the Nation is paying in poor quality health care.

Many of the issues that will be discussed are not new to this subcommittee. Nearly a decade ago this subcommittee was already holding hearings on kickbacks in clinical laboratories and billing practices by doctors and laboratories. These cost the Medicare and Medicaid programs millions of dollars which belong to the taxpayer. Unfortunately, hearings held several years later in 1988 identified similar kinds of sleazy practices. Following the hearings, the Congress revamped the Federal laboratory laws and passed anti-kickback legislation giving more teeth to regulators and prosecutors.

Today, however, we will hear that serious problems persist and that fraud in clinical laboratory activities is just one of many areas in the evolving medical marketplace that are ripe for abuse. What we are finding is that scams formerly associated with used car dealers, junk bond salesmen, and boiler room operators are being refined and taken uptown. We are finding that in many cases that health care providers, doctors and pharmacists, in whom the public puts trust, are committing out and out fraud. They are turning a tremendous profit at our expense, both in economic and human terms.

To cite just a few examples, in New York a grand jury indicted two radiologists and four ultrasound companies for stealing more than $1.25 million by fraudulent billing for sonograms that no physician had ordered.

In Florida, a home health care agency was convicted on one count of grand theft. One of the company's employees had to pay $300,000 to the Department of Health and Human Services, as well as a $40,000 fine.

A case filed against American Home Health Care Products revealed that the company and its associates had received $9.1 million by submitting false claims in the space of 1½ years.

These are just a few cases. We could mention many more.

As we will be hearing in just a few minutes, this problem is both massive and nationwide. It exists in every State and in every kind of community—urban, suburban, and rural. It affects each and every American. These are not crimes without victims. Directly or indirectly, each and every one of us is paying for the huge costs imposed by fraud and abuse in the health care system of the United States. Each and every one of us is paying for the selfishness, arrogance and greed of those who wrong not only the system but the persons dependent upon it.

We are also, unfortunately, paying for the weakness, ignorance, and shortsightedness of addicts and other desperate people who allow themselves to be used by slick operators, often for a pathetically paltry return, and also at the expense of their neighbors who genuinely need the services of an honest health care provider.

We are paying for this epidemic of fraud and abuse with constantly increasing insurance premiums—sky-high premiums now that put insurance beyond the means of more and more companies and workers. The Nation is paying for it with the loss of other programs—programs in education, housing, transportation, and other critical areas.

These programs are being slashed because health care costs the States and Federal Government more and more. The Nation is paying for it with illnesses and sometimes even the deaths of those who cannot or do not get health care because the resources that they need have been stolen. And last, but certainly not least, the Nation is paying for it with our tax dollars.

Each of the witnesses before the subcommittee today is uniquely qualified to help us understand the nature and the scope of the massive fraud problem that is sapping the strength of our health care system and that is soaking up millions or perhaps even billions of dollars that ought to be going to honest providers for the benefit of patients truly in need.

The subcommittee will be learning with this problem from the perspective of State and Federal Government law enforcement officers. We will also hear about the problem from the street, from a man who himself abused the system in the past and knows personally, from the inside, exactly how the system works or, more precisely, doesn't work.

Our distinguished panel of law enforcement experts includes Mr. Larry Morey from the Inspector General's Office at the Department of Health and Human Services, and Mr. William Esposito of the White Collar Crime Section at the FBI, who will describe for us

the types of health care fraud that they have identified and how these frauds affect patient access to care and the quality of care received. They will also detail to us some of their closed cases and discuss the obstacles they confront in their daily efforts to shut down frauds and share with us their suggestions for possible legislative remedies.

Mr. Edward Kuriansky from the New York State Office of Medicaid Fraud Control will address the same questions from his perspective as a law enforcement leader in a State that has, perhaps more than any, been under siege by medical manipulators and by an assortment of scam artists.

Finally, the members of the committee will have their opportunity to direct their questions to Mr. Jan Koppelnick, a University of Maryland graduate, who, unfortunately, became an active participant in fraudulent prescription drug sales but is now, I am happy to say, cooperating with law enforcement authorities in the State of Maryland. Mr. Koppelnick is accompanied by Mr. Daniel Anderson, Deputy Chief of Maryland's Medicaid Fraud Control Unit.

The committee is grateful for the assistance of our witnesses, and we look forward to hearing their testimony as they appear before us today.

The Chair announces that the first panel will be Mr. Larry D. Morey, Deputy Inspector General for Investigations at the Office of the Inspector General, Department of Health and Human Services, Washington, D.C.

Mr. Morey, we are delighted you are with us. We note that you are accompanied by Mr.——

Mr. MOREY. Robert Simon.

Mr. DINGELL. We welcome you both.

Are you going to be testifying also, Mr. Simon?

Mr. SIMON. I will be supplementing Mr. Morey's testimony.

Mr. DINGELL. It is the practice that all witnesses appearing before the committee are sworn and appear under oath.

Do either of you have any objection to appearing under oath at this particular time?

Mr. SIMON. Absolutely not.

Mr. MOREY. No.

Mr. DINGELL. The Chair advises that since you are appearing under oath, that it is your right to be advised by counsel.

Do either of you desire to be advised by counsel during your appearance here?

Mr. MOREY. No.

Mr. SIMON. No, sir.

Mr. DINGELL. Very well.

Gentlemen, the Chair advises that copies of the rules of the House, the rules of the committee, the rules of the subcommittee are there before you for the purposes of assisting you to understand both your rights and the limitations on the powers of the committee.

Gentlemen, if you have no objection to testifying under oath, if you will then each please rise and raise your right hand.

Gentlemen, do you solemnly swear the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

[Witnesses answer affirmatively]

Mr. DINGELL. Therefore, under oath, the Chair now recognizes my colleagues for the purposes of opening statements, starting with first the gentleman from Virginia, Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Today the subcommittee continues its series of hearings into the system of health care in the United States.

Earlier hearings have focused on such topics as the high cost of the present system, the persons covered and not covered by it, and proposals to reform it. Today the subcommittee examines waste, fraud and abuse in the system.

Waste, fraud and abuse are distressing in any government program but perhaps especially revolting in programs to aid the sick. We are fortunate to have before us today some of the people who are on the front lines in that battle. The Inspector General of the Department of Health and Human Services, working with the Federal Bureau of Investigation, is responsible for investigating allegations of waste, fraud and abuse in the Medicare and Medicaid programs. Both the HHS Inspector General and the FBI work with U.S. attorneys to develop cases for criminal prosecution.

Less serious cases of waste and abuse are generally dealt with through civil remedies administered by the Department of Health and Human Services itself.

At the State level, the burden falls on the Medicaid Fraud Control Unit within the State Attorney General's Office. These units must investigate allegations of waste, fraud and abuse, coordinate cases of fraud with appropriate prosecutors and support administrative actions in cases of waste and abuse.

Today's witnesses will offer invaluable testimony about where the existing Medicaid system is vulnerable. We have a rare, unique witness today, a recovering drug addict who will describe how the Medicaid system can be abused to secure prescription drugs for resale on the street markets.

While none of us would want to acquire the experience that this witness has firsthand, I am sure that we will find his description of the actual operations of the Medicaid system compelling and very informative.

Mr. Chairman, I commend you for this series of hearings to better inform members of this subcommittee about this important public policy question. Thank you.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair observes that there has been extraordinary cooperation between both the subcommittee staff and the very fine staff of the minority and that we appreciate the very fine way in which we have worked together. This is not a partisan inquiry, but rather it is one which has been conducted in a fully bipartisan way.

The Chair recognizes now my good friend from Georgia, Dr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman. I commend you for initiating this investigation.

We are all painfully aware of the serious crisis we face in our health care system today. There are millions of Americans going without any health care, countless more who can't get the care that they need, people at times are being subjected to poor quality

of care and, at the same time, the price of health care is rising astronomically.

As a physician, I am always particularly distressed to hear that already scarce resources are wasted through abusive and outright fraudulent practices. From my perspective, these wasted dollars could be spent on providing more health care to more people, people who are going without that now.

We can't seem to implement the most effective health care programs, for example, comprehensive preventative programs. Instead, we are trying to cope with a system that misses much of the fraud and abuse that does occur but that simultaneously imposes nearly impossible administrative demands on the hundreds of thousands of providers who are truly committed to the patients they serve.

The cure for our ailing health care system is not simple. The problems are very complex, and so, too, are the causes. I look forward to working with you to find a remedy that will insure access to good quality medical care for all our people and to assist the many providers who devote their lives to patients' well-being.

Most of the providers out there, Mr. Chairman, are people who are truly committed to providing good quality care for their people, and it is just a shame that there are a few who are so abusing this system even to the point of fraud, and so I look forward to continuing these hearings.

Thank you, Mr. Chairman. Yield back.

Mr. DINGELL. The Chair thanks the gentleman.

The gentleman from Oregon, Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman.

Briefly, let me commend you, Mr. Chairman, for initiating this important inquiry. It is quite clear in this member's mind that the medical buccaneers who are constantly trying to invent new ways to rip off our health care system are clearly growing more inventive, and I think it is particularly important to turn this committee's attention to these abuses.

The other point I would want to mention, Mr. Chairman, is it is quite clear that the staff has found that literally billions of dollars are being wasted on these kinds of frauds and abuses. Given the fact that there is tremendous interest in this country in developing a national health care system, it would seem to me that rooting out these kinds of frauds and abuses would make possible the directing of billions of dollars of new funds to establish a national health system and particularly to pick up some of the needs of those who are uninsured.

So this is an important inquiry, Mr. Chairman, and I look forward to pursuing it with you.

Mr. DINGELL. The Chair thanks the gentleman.

Mr. Morey, Mr. Simon, we thank you for being with us, and we will be delighted to hear your statement.

TESTIMONY OF LARRY D. MOREY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ROBERT A. SIMON, ASSISTANT INSPECTOR GENERAL

Mr. MOREY. Good morning, Mr. Chairman.

I am Larry Morey, the Deputy Inspector General for Investigations at the Department of Health and Human Services. With me this morning is Robert Simon, the Assistant Inspector General for Criminal Investigations. We are here this morning at your request to discuss our involvement in a variety of Medicaid and Medicare fraud investigations, especially those dealing with the pharmacies and laboratories.

We are also prepared to discuss our work in the anti-kickback arena. We are prepared to address the magnitude of fraudulent practices within these areas, as well as discuss a number of related OIG reports. With your permission, we will submit these for the record, and I would request that my complete statement be entered for the record.

The Office of the Inspector General is responsible for overseeing about 300 programs for our Department. We focus many of our efforts and resources on the Medicare and Medicaid programs. These programs account for a significant part of the Department's budget, and sheer magnitude of these programs make them vulnerable to fraud, waste and abuse.

Funding spent on the Office of the Inspector General is a sound investment. In fiscal year 1991, the Department of Health and Human Services spent over $100 billion for the health care of more than 34 million beneficiaries. During that time, each dollar invested in our office resulted in savings of over $62.

Fiscal year 1991 marked our 11th consecutive increase in accomplishments. Of the 2,348 successful criminal prosecutions and administrative sanctions we attained last year, nearly one-half were directly related to health care fraud.

The OIG has launched numerous initiatives in the health care area. As I mentioned previously, today we will be focusing on our investigations into the pharmacies and laboratories, as well as our work in the anti-kickback arena. Several initiatives involve joint efforts with the Federal Bureau of of Investigation and other Federal and local law enforcement agencies against doctors and medical suppliers who file false Medicare and Medicaid claims.

First, I would like to discuss our investigations of pharmacies, pharmacists and other individuals committing fraud against the Medicaid program. I know that this subcommittee is extremely familiar with variations of drug fraud. Therefore, I would just like to highlight some of the fraud schemes we have investigated. Fraud schemes involved fictitious billings, generic substitutions, split prescriptions, short counting and reuse of drugs.

We have included in our testimony several examples which describe these fraudulent schemes. Over the last 5 years, we have completed about 625 successful actions against pharmacies and their employees.

The most directly-abused prescription drugs are all available through the Medicaid program. Traditionally, little attention has been given to the pharmacies or to the physician that prescribes these drugs in great quantities, the pharmacies that dispense them and the recipients that either abuse them or sell them on the street.

With the help of the Drug Enforcement Administration, the OIG developed a computer software package entitled "The Medicaid

Abuseable Drug Audit System," and it allows us to determine those abusers and determine the street value. We have made this program available to every State and offered our assistance in implementing the system.

Now I would like to turn our investigative roles to the laboratory area. Again, we recognize your familiarity with this issue, and, therefore, I will summarize my comments. Fraud schemes involve billing for services not rendered, unauthorized or excessive tests, automated vs. manual testing fees, and double billing.

The first and most elementary scheme is to submit claims for services never rendered. In addition to costing Medicaid millions of wasted dollars, this simple scheme can have disastrous effects as it pertains to the patient. If the test was ordered by the doctor, the fictitious results provided by the laboratory gives a false picture of the patient's physical condition. If the tests were ordered, the false results may later affect the diagnosis.

In the last 5 years almost 50 convictions and civil actions have been obtained as a result of laboratory investigations. In January of 1990, we issued a report entitled, Changes Needed in the Way Medicare Pays for Clinical Laboratory Tests. We determined that Medicare, which pays for tests based on fee schedules, was paying nearly twice as much as physicians for the same clinical tests. Much of the payment differences was attributed to the way in which Medicare reimbursed for these battery of tests.

We recommend that HCFA bring the Medicare fee schedule allowance in line with the prices physicians paid when they purchased from independent laboratories. We concluded that rolling laboratory reimbursements into an office visit payment appears to be a promising strategy for curbing the use of laboratory services. Laboratory roll-ins would consolidate Medicare reimbursements for individual laboratory tests into recognized charges for physicians' office visits, and implementing this system would provide physicians with incentives to assure appropriate use of clinical laboratory services and lower Medicare administrative costs.

We found that if we would use this system we could save Medicare $12 billion over the next 5 years.

Finally, I would like to turn to the issue of kickback enforcements. The OIG continues to investigate violations of the anti-kickback statute which provides criminal penalties for individuals or entities participating in Medicare or Medicaid that knowingly and willfully solicit, receive, offer or pay anything of value to induce or in return for these actions are felons subject to fines up to $25,000, imprisonment up to 5 years or both.

Over the last 5 years, we have received more than 1250 allegations of violations of the anti-kickback statute and have opened over 800 cases. Close to 550 convictions, settlements and exclusions have been obtained as a result of our investigations as well as over $16 million in monetary recoveries.

Finally, we have also examined the range of drug promotion practices that involve physicians receiving money or other items of value from pharmaceutical companies. We found that pharmaceutical companies offer money and other items of value to physicians for a range of purchases, from sponsoring important educational activities to actively promoting their products. These promotional

practices appeared to affect physicians' prescribing decisions. Accordingly, we are currently investigating kickback cases involving promotional practices of pharmaceutical companies.

Careful monitoring of the health care industry is vital because the money involved is substantial, the potential for abuse is significant, and the need for quality care rendering efficiency is essential. Fraud schemes weaken the essential public benefits that we expect from all health care providers. However, we believe that our efforts are a major step in reducing these abuses and assuring quality health care for patients.

This concludes my oral statement, and I would be happy to answer your questions.

[Testimony resumes on p. 26.]

[The prepared statement of Mr. Morey follows:]

STATEMENT BY

LARRY D. MOREY
DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

GOOD MORNING, I AM LARRY MOREY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS OF THE OFFICE OF INSPECTOR GENERAL (OIG), DEPARTMENT OF HEALTH AND HUMAN SERVICES. WITH ME IS ROBERT SIMON, ASSISTANT INSPECTOR GENERAL FOR CRIMINAL INVESTIGATIONS. WE ARE HERE THIS MORNING AT YOUR REQUEST TO DISCUSS OUR INVOLVEMENT IN A VARIETY OF MEDICAID AND MEDICARE FRAUD INVESTIGATIONS, ESPECIALLY THOSE DEALING WITH THE PHARMACY AND LABORATORY INDUSTRIES. WE ARE ALSO PREPARED TO DISCUSS OUR WORK IN THE ANTI-KICKBACK ARENA. WE ARE PREPARED TO ADDRESS THE MAGNITUDE OF FRAUDULENT PRACTICES WITHIN THESE AREAS, AS WELL AS DISCUSS A NUMBER OF RELATED OIG REPORTS. WITH YOUR PERMISSION, WE WILL BE SUBMITTING THESE FOR THE RECORD.

BACKGROUND

THE OFFICE OF INSPECTOR GENERAL (OIG) IS RESPONSIBLE FOR OVERSEEING ABOUT 300 PROGRAMS FOR OUR DEPARTMENT. WE FOCUS MANY OF OUR EFFORTS AND RESOURCES ON THE MEDICARE AND MEDICAID PROGRAMS. THESE PROGRAMS ACCOUNT FOR A SIGNIFICANT PART OF THE DEPARTMENT'S BUDGET. THE SHEER MAGNITUDE OF THESE PROGRAMS MAKES THEM VULNERABLE TO FRAUD, WASTE, AND ABUSE.

FUNDING SPENT ON THE OFFICE OF INSPECTOR GENERAL IS A SOUND INVESTMENT. IN FISCAL YEAR 1991, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES SPENT OVER $100 BILLION FOR THE HEALTH CARE OF MORE THAN 34 MILLION BENEFICIARIES. DURING THAT TIME, EACH DOLLAR INVESTED IN OUR OFFICE RESULTED IN SAVINGS OF OVER $62.

WE ARE PROUD OF OUR STATISTICAL ACCOMPLISHMENTS AND THE SUCCESSES WE HAVE HAD IN ENSURING THAT THOSE INDIVIDUALS WHO DEFRAUD THE DEPARTMENT'S PROGRAMS ARE HELD ACCOUNTABLE FOR THEIR ACTIONS. IN FACT, FISCAL YEAR 1991 MARKED OUR 11TH CONSECUTIVE INCREASE IN PROSECUTORIAL ACCOMPLISHMENTS. OF THE 2,348 SUCCESSFUL CRIMINAL PROSECUTIONS AND ADMINISTRATIVE SANCTIONS WE ATTAINED LAST YEAR, NEARLY HALF WERE DIRECTLY RELATED TO HEALTH CARE.

INVESTIGATIVE ACTIVITIES

THE OIG HAS LAUNCHED NUMEROUS INITIATIVES IN THE HEALTH CARE AREA. AS I MENTIONED PREVIOUSLY, TODAY WE WILL BE FOCUSING ON OUR INVESTIGATIONS INTO THE PHARMACY AND LABORATORY INDUSTRIES, AS WELL AS OUR WORK IN THE ANTI-KICKBACK ARENA. SEVERAL INITIATIVES INVOLVE JOINT EFFORTS WITH THE FEDERAL BUREAU OF INVESTIGATION (FBI) AND OTHER FEDERAL AND LOCAL LAW ENFORCEMENT AGENCIES AGAINST DOCTORS AND MEDICAL SUPPLIERS WHO FILE FALSE MEDICARE AND MEDICAID CLAIMS.

PHARMACIES

FIRST, I WOULD LIKE TO DISCUSS OUR INVESTIGATIONS OF PHARMACIES, PHARMACISTS, AND OTHER INDIVIDUALS COMMITTING FRAUD AGAINST THE MEDICAID PROGRAM. UNDER THIS PROGRAM, THE PRICE OF A PRESCRIBED DRUG MUST BE THE LOWER OF EITHER (1) INGREDIENT COST PLUS A DISPENSING FEE, OR (2) THE PHARMACIST'S USUAL AND CUSTOMARY CHARGE TO THE GENERAL PUBLIC. THIS DOES NOT MEAN THAT EACH STATE WILL NECESSARILY HAVE A UNIFORM PRICE FOR EACH PARTICULAR DRUG,

SINCE VARYING ACQUISITION AND OVERHEAD COSTS ARE CONSIDERED.

FRAUD SCHEMES INVOLVE FICTITIOUS BILLINGS, GENERIC SUBSTITUTIONS, SPLIT PRESCRIPTIONS, SHORT-COUNTING, AND RE-USE OF DRUGS. THE FIRST SCHEME I'M GOING TO DESCRIBE IS FICTITIOUS BILLINGS. AS THEY FILL PRESCRIPTIONS, FOR EXAMPLE, PHARMACISTS ARE ABLE TO ACCUMULATE RECIPIENT DATA. ARMED WITH THIS DATA, THEY CAN FALSIFY BILLS FOR PRESCRIPTIONS WHICH WERE NEVER PRESCRIBED OR FILLED. A VARIATION OF THIS SCHEME INVOLVES COLLUSION OF THE RECIPIENT. IN THIS SCENARIO, RECIPIENTS BRING IN PRESCRIPTIONS TO PHARMACIES FOR DRUGS THAT ARE NOT WANTED OR NEEDED. THE RECIPIENTS AND THE PHARMACISTS AGREE TO EXCHANGE THE PRESCRIPTIONS FOR MERCHANDISE -- SUCH AS COSMETICS OR HOUSEHOLD ITEMS. THE PHARMACISTS THEN BILL MEDICAID AS IF THE PRESCRIPTION WAS FILLED.

THE SECOND SCHEME IS GENERIC SUBSTITUTION. A DRUG WILL SOMETIMES BE MARKETED UNDER VARYING BRAND NAMES, AS WELL AS ITS GENERIC SUBSTITUTE. USUALLY, THE GENERIC EQUIVALENT IS CHEAPER THAN THE BRAND NAME, AND THIS PRICE DIFFERENTIAL OFTEN REACHES 300 PERCENT. UNSCRUPULOUS PHARMACISTS WILL TAKE ADVANTAGE OF THIS PRICE DISPARITY AND FILL THE PRESCRIPTION WITH A GENERIC DRUG, BUT BILL THE MEDICAID PROGRAM FOR THE BRAND NAME DRUG.

THE THIRD SCHEME INVOLVES SPLIT PRESCRIPTIONS. A PRESCRIPTION CALLS FOR A GIVEN SUPPLY OF A DRUG. PART OF THE REIMBURSEMENT

GIVEN TO THE PHARMACY IS THE DISPENSING FEE. IN ORDER TO ARTIFICIALLY CREATE ADDITIONAL REVENUE, SOME PHARMACISTS WILL NOT COMPLETELY FILL THE ORIGINAL PRESCRIPTION. INSTEAD, THEY WILL SUPPLY ONLY HALF, OFTEN WITH THE EXCUSE THAT THEY ARE OUT OF THE DRUG OR THE DRUG IS IN LOW SUPPLY. THE PHARMACIST TELLS THE RECIPIENT TO COME BACK IN A FEW DAYS WHEN THE BALANCE OF THE PRESCRIPTION WILL BE FILLED. SINCE ANOTHER PRESCRIPTION IS NOT NECESSARY, THE PHARMACIST NOT ONLY RECEIVES THE NORMAL PROFIT ON THE PRESCRIPTION, BUT HAS INCREASED THE REIMBURSEMENT BY BILLING FOR THE DISPENSING FEE TWICE.

THE FOURTH SCHEME INVOLVES SHORT-COUNTING. WHENEVER A PRESCRIPTION CALLS FOR NUMEROUS PILLS OR CAPSULES, OR A SUBSTANTIAL QUANTITY OF A CREAM OR LIQUID, IT IS AN EASY MATTER FOR THE PHARMACIST TO UNDERCOUNT OR UNDERSUPPLY THE PRESCRIPTION. WITHOUT INSIDE INFORMATION, THE SCHEME IS DIFFICULT TO DETECT. EVEN IF UNCOVERED -- OFTEN IN A GENERIC SUBSTITUTION INQUIRY -- THE ELEMENT OF INTENT MAY BE DIFFICULT TO PROVE.

THE FIFTH SCHEME INVOLVES RE-USE OF DRUGS. MOST JURISDICTIONS HAVE REGULATIONS GOVERNING THE DISPOSAL OF PRESCRIPTION DRUGS REMAINING WHEN A PATIENT DIES. A TYPICAL REGULATION REQUIRES THESE UNUSED DRUGS TO BE RETURNED TO THE PHARMACY FOR DESTRUCTION. THE PHARMACY MUST CERTIFY THAT THIS WAS IN FACT DONE. THIS FRAUDULENT SCHEME INVOLVES THE RETURN OF THE DRUGS TO GENERAL SALE STOCK, OR THE DIVERSION TO ILLEGAL STREET SALES.

LET ME PROVIDE YOU WITH EXAMPLES OF CASES INVOLVING PHARMACIES AND THEIR EMPLOYEES.

- DOCTORS AND A PHARMACIST CONSPIRED TO BILL MEDICAID FOR MEDICALLY UNNECESSARY DRUGS AND OTHER ITEMS. MEDICAID RECIPIENTS THEN SOLD THE DRUGS ON THE STREET OR MISUSED THE DRUGS THEMSELVES. THIS SCAM COST THE PROGRAM $40 MILLION. INVESTIGATION OF THIS SCHEME, WHICH INVOLVED THE USE OF UNDERCOVER OPERATIVES, RESULTED IN 23 CONVICTIONS.

- IN MICHIGAN, INVESTIGATORS OF THE OIG, FBI, BLUE CROSS/BLUE SHIELD AND MICHIGAN STATE POLICE TARGETED MEDICAL PROVIDERS SUSPECTED OF DEALING IN PRESCRIPTION FRAUD AND FALSE BILLINGS FOR SERVICES. TO DATE, 13 HAVE BEEN CONVICTED, AMONG THEM A PHYSICIAN WHO ILLEGALLY SOLD PRESCRIPTION DRUGS AND COCAINE AND ENGAGED IN A LABORATORY KICKBACK SCHEME. THE CASES INVESTIGATED INVOLVED LOSSES TO MEDICAID AND MEDICARE OF MORE THAN $ 1.6 MILLION.

OVER THE LAST FIVE YEARS, WE HAVE COMPLETED ABOUT 625 SUCCESSFUL ACTIONS AGAINST PHARMACIES AND THEIR EMPLOYEES. A MAIN FOCUS OF THE OIG HAS BEEN ON CONTROLLED SUBSTANCES. WE REMAIN CONCERNED ABOUT THE INTERNAL CONTROL SYSTEM MEDICAID AGENCIES USE TO CHECK THE USE OF FREQUENTLY ABUSED PRESCRIPTION DRUGS.

THE 15 MOST FREQUENTLY ABUSED PRESCRIPTION DRUGS ARE ALL AVAILABLE THROUGH THE MEDICAID PROGRAM. TRADITIONALLY, LITTLE ATTENTION HAS BEEN GIVEN THE PHYSICIANS THAT PRESCRIBE THESE DRUGS IN GREAT QUANTITY, THE PHARMACIES THAT DISPENSED THEM AND THE RECIPIENTS THAT ABUSED THEM OR SOLD THEM ON THE STREET.

WITH THE HELP OF THE DRUG ENFORCEMENT ADMINISTRATION, THE OIG DEVELOPED A COMPUTER SOFTWARE PACKAGE, ENTITLED THE MEDICAID ABUSABLE DRUG AUDIT SYSTEM (MADAS), CAPABLE OF IDENTIFYING

PHYSICIANS, PHARMACIES, AND RECIPIENTS THAT DEAL IN ABNORMAL QUANTITIES OF SCHEDULE II THROUGH V PRESCRIPTION DRUGS WITH A HIGH STREET VALUE, AND CATEGORIZING AND PRIORITIZING THE IDENTIFIED TARGETS. WE HAVE MADE THIS PROGRAM AVAILABLE TO EVERY STATE AND OFFERED OUR ASSISTANCE IN IMPLEMENTING THE SYSTEM. TO DATE, NINE STATES HAVE IMPLEMENTED THE OIG PROGRAM, SEVEN STATES ARE INSTALLING AND TESTING THE PROGRAM, AND TWO STATES HAVE REQUESTED THAT WE GENERATE THE INITIAL RUNS FOR THEM. ANOTHER 22 STATES ARE REVIEWING THE TECHNICAL DATA TO DETERMINE COMPATIBILITY WITH THEIR CURRENT SYSTEMS. WE ARE SUBMITTING A COPY OF OUR REPORT ENTITLED "OIG GENERAL INITIATIVE TO IMPROVE STATES' INTERNAL CONTROLS OVER PRESCRIPTION DRUGS IN THE MEDICAID PROGRAM".

IN JULY 1990, WE RELEASED A STUDY ENTITLED "STATE DISCIPLINE OF PHARMACISTS", WHICH ASSESSED THE DISCIPLINARY PRACTICES OF STATE BOARDS OF PHARMACY. ALTHOUGH STATES HAVE TAKEN IMPORTANT STEPS TO STRENGTHEN STATE PHARMACY BOARDS IN RECENT YEARS, WE FOUND SERIOUS LIMITATIONS IN STATE BOARDS' DISCIPLINING OF PHARMACISTS. DURING OUR REVIEW, THERE WERE FEW SERIOUS TYPES OF DISCIPLINARY ACTIONS TAKEN IN MANY STATES. OF THOSE TAKEN, MOST WERE RELATED TO DRUG DIVERSIONS AND DRUG ABUSE, RATHER THAN QUALITY OF CARE ISSUES. WE ALSO FOUND THAT THE ABILITY OF MANY PHARMACY BOARDS TO PROTECT THE PUBLIC IS HAMPERED BY INSUFFICIENT LEGAL AUTHORITIES, TIME-CONSUMING DISCIPLINARY PROCESSES, AND INADEQUATE RESOURCES.

WE RECOMMENDED THAT STATE GOVERNMENTS ENSURE ADEQUATE AUTHORITY AND RESOURCES FOR PHARMACY BOARDS AND STREAMLINE THE DISCIPLINARY PROCESSES SO BOARDS CAN DISCIPLINE MORE EFFECTIVELY AND EFFICIENTLY. WE ALSO RECOMMENDED THAT THE PUBLIC HEALTH SERVICE ASSIST THE NATIONAL ASSOCIATION OF BOARDS OF PHARMACY IN ITS EFFORTS TO PROVIDE LEADERSHIP TO STATE PHARMACY BOARDS.

CLINICAL LABORATORIES

NOW I WOULD LIKE TO TURN TO OUR INVESTIGATIVE ROLE IN THE LABORATORY AREA. BY WAY OF BACKGROUND, CLINICAL LABORATORIES ARE FACILITIES WHICH PERFORM MEDICAL TESTS USED IN THE DIAGNOSIS, PREVENTION, OR TREATMENT OF DISEASE. THESE TESTS INVOLVE BODILY FLUIDS OR TISSUE, SUCH AS BLOOD, URINE, AND LUNG TISSUE. EACH YEAR BETWEEN 4 AND 6 BILLION CLINICAL TESTS ARE PERFORMED. THE MAJORITY OF THESE TESTS ARE PERFORMED IN HOSPITALS, PHYSICIAN OFFICE LABORATORIES, AND INDEPENDENT LABORATORIES.

SINCE THE MID-1960s, ABOUT 12,000 MEDICARE LABORATORIES, AND LABORATORIES SENDING SPECIMENS IN INTERSTATE COMMERCE, HAVE BEEN REGULATED UNDER THE CLINICAL LABORATORIES IMPROVEMENT ACT OF 1967 (CLIA). CLIA IMPOSES ON LABORATORIES A CERTIFICATION MECHANISM UNDER WHICH THEY MUST MEET SPECIFIED STANDARDS, PERMIT INSPECTIONS, SUBMIT REPORTS, MAKE RECORDS AVAILABLE, AND SUBMIT TO PROFICIENCY TESTING. THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988 (CLIA '88), WHICH THIS COMMITTEE WAS INSTRUMENTAL IN PASSING, EXPANDED THIS REGULATION TO ALL CLINICAL

LABORATORIES. THE LAW AUTHORIZES CRIMINAL AND CIVIL PENALTIES FOR PERSONS WHO INTENTIONALLY VIOLATE CLIA.

THE BASIC SYSTEM BEHIND LABORATORY BILLING IS THAT EACH TEST PROCEDURE (IDENTIFIED BY A SPECIFIC CODE NUMBER) IS REIMBURSED, USUALLY ACCORDING TO A FEE SCHEDULE, WHICH MAY VARY FROM LOCALITY TO LOCALITY. PHYSICIANS MUST ORDER THESE TESTS. MOST PATIENTS HAVE LITTLE OR NO COMPREHENSION AS TO WHAT SPECIFIC TESTS ARE ORDERED, THE REASONS BEHIND THEM, OR EVEN WHAT LABORATORY PERFORMS THEM. THIS SITUATION MAKES FRAUD THAT MUCH MORE SUBTLE, ESPECIALLY IF THE PHYSICIAN IS INVOLVED IN THE FRAUD.

I WOULD NOW LIKE TO PROVIDE BRIEF SUMMARIES OF THE MOST COMMON TYPES OF LABORATORY FRAUD SCHEMES. THESE INVOLVE BILLING FOR SERVICES NOT RENDERED, UNAUTHORIZED OR EXCESSIVE TESTS, AUTOMATED VS. MANUAL TESTING FEES, AND DOUBLE-BILLING.

THE FIRST, AND MOST ELEMENTAL, SCHEME IS TO SUBMIT CLAIMS FOR SERVICES NEVER RENDERED. IN ADDITION TO COSTING MEDICARE MILLIONS OF WASTED DOLLARS, THIS SIMPLE SCHEME CAN HAVE DISASTROUS RESULTS AS IT PERTAINS TO THE PATIENT. IF THE TEST WAS ORDERED BY THE DOCTOR, THE FICTITIOUS RESULTS PROVIDED BY THE LABORATORY GIVE A FALSE PICTURE OF THE PATIENT'S PHYSICAL CONDITION; IF THE TESTS WERE NOT ORDERED, THE FALSE RESULTS MAY AFFECT LATER DIAGNOSES OR UNNECESSARILY MUDDLE THE PRESENT PATIENT EVALUATION, POSSIBLY CAUSING ADDITIONAL EXPENSE.

THE SECOND SCHEME INVOLVES UNAUTHORIZED OR EXCESSIVE TESTS. A LABORATORY SHOULD PERFORM ONLY THOSE TESTS WHICH THE PHYSICIAN ORDERS. MANY TIMES, HOWEVER, A LABORATORY WILL PERFORM AND BILL FOR TESTS NEVER ORDERED AND WHICH ARE NOT MEDICALLY NECESSARY. IN ORDER TO FACILITATE THIS SCHEME, A LABORATORY WILL SUPPLY THE PHYSICIANS WITH AN ORDER FROM WHICH WILL LINK TESTS TO ONE ANOTHER, EVEN IF NOT WARRANTED. THIS RESULTS IN THE PHYSICIAN ORDERING TESTS A AND B, WHEN ALL THAT WAS REALLY NEEDED (AND WANTED) WAS TEST A. OCCASIONALLY, THE LABORATORY WILL ACTUALLY PERFORM THE TEST ORDERED, BUT WILL BILL FOR A RELATED AND MORE EXPENSIVE ONE.

- WE HAD A CASE INVOLVING THE OWNER OF A LABORATORY IN ILLINOIS. HE CLAIMED THE SINGLE DRAWING FEE OF $5 FOR SERVICES TO 50 PATIENTS A DAY, WHEN HE SHOULD HAVE CHARGED THE MULTIPLE PATIENT RATE OF $3 EACH. HE ALSO BILLED FOR DRAWINGS WHEN THE ONLY TESTS WERE URINALYSIS. HE WAS ORDERED TO REPAY $24,000 HE HAD OBTAINED FRAUDULENTLY.

THE THIRD SCHEME INVOLVES AUTOMATED VS. MANUAL TESTING FEES. IN THE PAST, LABORATORY TESTING WAS DONE MANUALLY. TECHNOLOGY HAS BROUGHT AUTOMATION TO THE CLINICAL LABORATORY. MOST JURISDICTIONS, REALIZING THAT MANUAL TESTS COST MORE THAN THEIR AUTOMATED COUNTERPARTS, ALLOW FOR A HIGHER FEE IF THE TEST IS MANUALLY DONE. THIS SITUATION CREATES THE OPPORTUNITY FOR FRAUD:

- MANY SMALL LABORATORIES DO NOT POSSESS THE CAPITALIZATION TO PURCHASE EXPENSIVE, AUTOMATED TESTING MACHINERY. THESE LABORATORIES WILL SUBCONTRACT INCOMING WORK TO A LARGER, AUTOMATED LABORATORY, AND THEN BILL THE HEALTH CARE CARRIER FOR THE HIGHER MANUAL RATE. PART OF THE PROBLEM IS THAT THE AVAILABLE FEES (FOR MANUAL TESTING) ARE SET QUITE HIGH, THUS MAKING IT ECONOMICALLY FEASIBLE FOR AN OFFENDING LABORATORY TO EMPLOY THIS SCHEME.

AUTOMATION PERMITS THE LABORATORY TO RUN SEVERAL (BATTERY) TESTS WITH A SINGLE SAMPLE. SOME LAB OWNERS WILL OFTEN DISGUISE THE NATURE OF THE TESTS PERFORMED, AND CHARGE THE PROGRAM AS IF INDIVIDUAL UNIT TESTS WERE DONE. THIS SCHEME IS OFTEN ACCOMPLISHED BY BILLING FOR HALF THE TESTS ON ONE DATE, AND CLAIMING A DIFFERENT SERVICE DATE FOR THE REMAINING TESTS.

THE FOURTH SCHEME INVOLVES DOUBLE BILLING. SOMETIMES A LABORATORY, IN ADDITION TO BILLING MEDICARE OR MEDICAID, WILL ALSO COLLECT FROM THE PATIENT, OR SOME OTHER THIRD PARTY INSURER. BECAUSE THESE PROGRAMS ARE THE PAYOR OF LAST RESORT, THIS CONDUCT IS FRAUDULENT.

- WE HAD A CASE INVOLVING A WEST VIRGINIA DOCTOR WHO BILLED MEDICARE FOR TESTS ACTUALLY PERFORMED BY A BILLING SERVICE, SOME OF WHICH HE HAD BILLED TO BLUE CROSS. HE BILLED MEDICARE FOR $450 FOR EACH SERIES OF TESTS HE CLAIMED TO HAVE PERFORMED IN HIS OFFICE. THE LABORATORY CHARGED HIM ONLY $18 FOR EACH AND NOTHING AT ALL FOR TESTS TO INDIGENTS. THE DOCTOR AGREED TO PAY FULL RESTITUTION OF $12,200 TO MEDICARE, $750 TO BLUE CROSS, $150 TO THE STATE WORKERS' COMPENSATION PROGRAM AND $8,000 TO OIG FOR INVESTIGATIVE COSTS. HE ALSO AGREED TO PAY ALL TAX LIABILITIES HE INCURRED BY NOT REPORTING CASH PAYMENTS TO HIS OFFICE.

IN THE LAST FIVE YEARS, ALMOST 50 CONVICTIONS AND CIVIL ACTIONS HAVE BEEN OBTAINED AS A RESULT OF OUR LABORATORY INVESTIGATIONS. WE BELIEVE THAT LABORATORY FRAUD IS PARTICULARLY SERIOUS IN LIGHT OF THE EXPANSIONS OF NEW TECHNOLOGIES, AND THE IDENTIFICATION OF LIFE-THREATENING DISEASES, AS WELL AS THE CRITICAL NEED FOR EARLY DETECTION OF CERTAIN ILLNESSES. THUS, LABORATORIES ARE ONE OF THE MANY AREAS THAT THE OIG HAS FOCUSED ON OVER THE YEARS.

I WOULD LIKE TO MAKE SOME ADDITIONAL COMMENTS ON MEDICARE PAYMENTS FOR CLINICAL LABORATORY SERVICES. AS I MENTIONED PREVIOUSLY, MEDICARE PAYS FOR A CLINICAL LABORATORY SERVICE ON THE BASIS OF A FEE SCHEDULE ESTABLISHED FOR A PARTICULAR GEOGRAPHIC AREA. THIS FEE SCHEDULE WAS ESTABLISHED BY CONGRESS IN 1984 AS A MEANS TO CONTROL MEDICARE EXPENDITURES FOR THESE SERVICES. SINCE THEN, CONGRESS HAS CONTINUED TO EXAMINE REIMBURSEMENT ISSUES. MANY SUBSEQUENT AMENDMENTS WERE DESIGNED TO RESPOND TO THE CONCERN THAT MEDICARE WAS STILL PAYING MORE THAN NECESSARY FOR LABORATORY TESTS. MODIFICATIONS INCLUDED PLACING A NATIONAL LIMIT ON PAYMENT AMOUNTS, REDUCING PAYMENT FOR CERTAIN TESTS, AND RESTRICTING THE TYPES OF LABORATORIES THAT COULD QUALIFY FOR PAYMENT UNDER THE FEE SCHEDULE.

IN JANUARY 1990, WE ISSUED A REPORT ENTITLED "CHANGES ARE NEEDED IN THE WAY MEDICARE PAYS FOR CLINICAL LABORATORY TESTS". WE DETERMINED THAT MEDICARE, WHICH PAYS FOR TESTS BASED ON FEE SCHEDULES, WAS PAYING NEARLY TWICE AS MUCH AS PHYSICIANS FOR THE SAME CLINICAL TESTS. MUCH OF THE PAYMENT DIFFERENCE WAS ATTRIBUTABLE TO THE WAY IN WHICH MEDICARE REIMBURSED BATTERIES OF TESTS -- KNOWN AS PROFILES -- ORDERED AS A GROUP BY PHYSICIANS.

WE RECOMMENDED THAT HCFA BRING THE MEDICARE FEE SCHEDULE ALLOWANCES IN LINE WITH THE PRICES PHYSICIANS ARE PAYING FOR TESTS PURCHASED FROM INDEPENDENT LABORATORIES; DEVELOP POLICIES AND PROCEDURES TO MORE APPROPRIATELY HANDLE PROFILES; AND WORK

WITH CONTRACTORS TO FURTHER STREAMLINE THE PROCESSING OF LABORATORY BILLS.

IN OCTOBER 1990, WE ISSUED A REPORT ENTITLED "ENSURING APPROPRIATE USE OF LABORATORY SERVICES". THIS REPORT EXAMINED FORCES THAT ENCOURAGE USE OF CLINICAL LABORATORY SERVICES AND CONSIDERED VARIOUS SOLUTIONS TO CONTROL INCREASES IN LABORATORY EXPENDITURES. WE FOUND THAT MEDICARE PAYMENTS FOR LABORATORY SERVICES MORE THAN DOUBLED. THUS, ADOPTION OF THE FEE SCHEDULE DID NOT APPEAR TO REDUCE MEDICARE EXPENDITURES FOR LABORATORY SERVICES OR SLOW THE RATE OF GROWTH.

WE CONCLUDED THAT ROLLING LABORATORY REIMBURSEMENT INTO OFFICE VISIT PAYMENTS APPEARS TO BE A PROMISING STRATEGY FOR CURBING THE USE OF LABORATORY SERVICES. LABORATORY ROLL-INS (LRIs) WOULD CONSOLIDATE MEDICARE REIMBURSEMENT FOR INDIVIDUAL LABORATORY TESTS INTO THE RECOGNIZED CHARGE FOR PHYSICIAN OFFICE VISITS. IMPLEMENTATION OF THE LRI WOULD PROVIDE PHYSICIANS WITH INCENTIVES TO ENSURE APPROPRIATE USE OF CLINICAL LABORATORY SERVICES AND LOWER MEDICARE'S ADMINISTRATIVE COSTS.

IN A FOLLOW-UP REPORT, "IMPACT OF A LABORATORY ROLL IN ON MEDICARE EXPENDITURES", WE FOUND THAT LRIs COULD SAVE MEDICARE MORE THAN $12 BILLION OVER 5 YEARS. WE ALSO FOUND THAT LRIs WOULD PROVIDE SUFFICIENT FUNDS FOR MOST PHYSICIANS TO COVER THE COSTS THEY WOULD INCUR IN SECURING LABORATORY WORK. WE

RECOMMENDED THAT HCFA ANALYZE THE LRI REIMBURSEMENT MECHANISM FOR LABORATORY SERVICES, AND PROPOSE LEGISLATION TO IMPLEMENT IT WITHIN 2 YEARS. HCFA HAS NOT YET ADOPTED THIS RECOMMENDATION.

KICKBACK ENFORCEMENT

THE OIG CONTINUES TO INVESTIGATE VIOLATIONS OF THE ANTI-KICKBACK STATUTE, WHICH PROVIDES CRIMINAL PENALTIES FOR INDIVIDUALS OR ENTITIES PARTICIPATING IN MEDICARE OR MEDICAID THAT KNOWINGLY AND WILLFULLY SOLICIT, RECEIVE, OFFER, OR PAY ANYTHING OF VALUE TO INDUCE OR IN RETURN FOR:

- REFERRING AN INDIVIDUAL TO A PERSON FOR THE FURNISHING OF ANY ITEM OR SERVICE, OR;
- PURCHASING, LEASING, ORDERING OR ARRANGING FOR OR RECOMMENDING PURCHASING, LEASING, OR ORDERING ANY GOOD, FACILITY, SERVICE, OR ITEM.

THESE ACTIONS ARE FELONIES SUBJECT TO FINES OF UP TO $25,000, IMPRISONMENT OF UP TO 5 YEARS, OR BOTH.

THE MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT (P.L. 100-93) BROADENED THE ANTI-KICKBACK STATUTE BY ESTABLISHING A CIVIL REMEDY TO PROTECT THE MEDICARE AND MEDICAID PROGRAMS. IF AN INDIVIDUAL OR ENTITY IS FOUND TO BE VIOLATING THE STATUTE, THE SECRETARY CAN EXCLUDE THEM FROM FUTURE PARTICIPATION IN THESE PROGRAMS. TO ILLUSTRATE THESE VIOLATIONS, I WOULD LIKE TO DISCUSS TWO BROAD KICKBACK SCHEMES INVOLVING PHARMACIES AND LABORATORIES.

FIRST, KICKBACKS INVOLVING PHARMACIES. BECAUSE PEOPLE CONFINED TO A HEALTH CARE FACILITY -- I.E. SKILLED NURSING FACILITY, HEALTH RELATED FACILITY, MENTAL HEALTH CLINIC, OLD AGE OR BOARDING HOME -- USE PRESCRIPTION DRUGS IN GREAT QUANTITIES, THE RIGHT TO SUPPLY A HOME IS HIGHLY VALUED. THEORETICALLY, PATIENTS CAN USE A PHARMACY OF THEIR OWN CHOOSING, BUT A "RECOMMENDATION" MADE BY THE FACILITY OF A PARTICULARLY RELIABLE OR CONVENIENT PHARMACY WILL CARRY GREAT WEIGHT. SIMILARLY, BECAUSE OF THE TRUST ONE PLACES IN A PHYSICIAN, A DOCTOR'S RECOMMENDATION OF A PARTICULAR PHARMACY IS HIGHLY VALUED. THIS SITUATION CAN LEAD TO ILLEGAL KICKBACKS BETWEEN FACILITY OWNERS AND A PHARMACISTS.

SECOND, KICKBACKS INVOLVING LABORATORIES. A CLINICAL LABORATORY IS A VERY COMPETITIVE ENTERPRISE; THE ABILITY TO GAIN THE BUSINESS OF A HEALTH CARE PROVIDER WITH A SUBSTANTIAL VOLUME WILL MEAN LARGE PROFITS. BECAUSE OF THE COMPETITION, LABORATORIES WILL GIVE INCENTIVES TO PHYSICIANS (OR OTHER SOURCES OF WORK) IN ORDER TO ATTRACT BUSINESS. THESE INCENTIVES VARY IN FORM AND SUBSTANCE. THE MOST OBVIOUS "INCENTIVE" IS A DIRECT CASH PAYMENT TO THE PROVIDER. SOMETIMES THESE CASH PAYMENTS ARE KEYED TO THE VOLUME OF BUSINESS REFERRED.

SINCE 1987, WE HAVE RECEIVED MORE THAN 1,250 ALLEGATIONS OF VIOLATIONS OF THE ANTI-KICKBACK STATUTE, AND HAVE OPENED OVER 800 CASES. CLOSE TO 550 CONVICTIONS, SETTLEMENTS, AND EXCLUSIONS HAVE BEEN OBTAINED AS A RESULT OF OUR INVESTIGATIONS, AS WELL AS

ALMOST $16 MILLION IN MONETARY RECOVERIES.

LET ME PROVIDE YOU WITH SOME EXAMPLES OF SUCCESSFUL CASES.

- THE CHIEF FINANCIAL OFFICER OF A HEALTH MANAGEMENT CORPORATION WAS SENTENCED IN NORTH CAROLINA TO 37 MONTHS IMPRISONMENT FOR MEDICAID AND BANKRUPTCY FRAUD. HIS CORPORATION MANAGED FOUR NURSING HOMES IN NORTH CAROLINA AND SOUTH CAROLINA. HE EXECUTED AN ELABORATE SCHEME IN WHICH A FOOD SUPPLIER ADDED $1,000 TO EACH BILL, WHICH WAS PAID BY A DIETARY CONSULTANT WHO IN TURN PAID KICKBACKS TO HIM. HE WAS SENTENCED TO 3 YEARS PROBATION, DURING WHICH HE MUST PERFORM 120 HOURS COMMUNITY SERVICE EACH YEAR AND PAY $63,000 IN RESTITUTION, PLUS $400 IN SPECIAL ASSESSMENTS.

- TWO PHYSICIANS SENTENCED TO PROBATION IN NEW YORK BROUGHT TO 18 THE NUMBER SENTENCED FOR KICKBACKS FROM A DME SUPPLIER. A TOTAL OF 25 HEALTH CARE PROFESSIONALS WERE ARRESTED IN THE CASE, INCLUDING THREE HUSBAND AND WIFE TEAMS. ALMOST $90,000 HAS BEEN ORDERED IN FINES, RESTITUTIONS AND SPECIAL ASSESSMENTS FROM THE PROFESSIONALS FOR ACCEPTING $50 OR MORE FOR EACH REFERRAL TO THE SUPPLIER. THE SUPPLIER AND ONE OTHER PHYSICIAN ARE AWAITING SENTENCING, AND SANCTIONING ACTIONS WERE INITIATED ON EACH INDIVIDUAL CONVICTED.

- THE OWNER OF A CALIFORNIA DIAGNOSTIC CLINIC WAS SENTENCED TO 3 YEARS PROBATION AND ORDERED TO PAY $1,400 IN RESTITUTION, A $5,000 FINE AND $5,000 FOR THE COST OF AN INVESTIGATION INTO MEDICARE FRAUD. THE CLINIC SUBMITTED UNNECESSARY PATIENT BILLINGS AND PAID KICKBACKS FOR REFERRALS IN THE FORM OF RENT SUBSIDIES.

WE HAVE EVALUATED THE KICKBACK ARENA FROM OTHER PERSPECTIVES. IN 1989, THE OIG RELEASED SEVERAL REPORTS SUMMARIZING THE FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES TO WHICH THEY REFER THEIR PATIENTS. THE MOST IMPORTANT OF THESE REPORTS, "FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES: REPORT TO CONGRESS", FOUND THAT 12 PERCENT OF PHYSICIANS WHO BILL MEDICARE HAVE OWNERSHIP AND INVESTMENT INTERESTS IN ENTITIES TO WHICH THEY MAKE PATIENT REFERRALS. WE

ALSO FOUND THAT SUCH ARRANGEMENTS WERE ASSOCIATED WITH INCREASED UTILIZATION OF SERVICES. PATIENTS OF REFERRING PHYSICIANS WHO OWN OR INVEST IN CLINICAL LABORATORIES RECEIVED 45 PERCENT MORE SERVICES THAN MEDICARE PATIENTS IN GENERAL. WE ESTIMATED THAT THIS INCREASED UTILIZATION OF LABORATORY SERVICES BY PATIENTS OF PHYSICIAN-OWNERS COST THE MEDICARE PROGRAM $28 MILLION.

IN JANUARY 1991, WE ISSUED A MANAGEMENT ADVISORY REPORT ENTITLED "FINANCIAL ARRANGEMENTS BETWEEN HOSPITALS AND HOSPITAL-BASED PHYSICIANS" IN WHICH WE DESCRIBE ARRANGEMENTS WHICH COULD VIOLATE THE ANTI-KICKBACK STATUTE. KICKBACK ARRANGEMENTS BETWEEN HOSPITALS AND PHYSICIANS MAY INVOLVE RECRUITMENT INCENTIVES, RENTALS OF EQUIPMENT OR SPACE, OR HOSPITAL PURCHASE OF A PHYSICIAN'S PRACTICE. WE LOOKED AT THE FEES HOSPITALS RECEIVE WHICH ARE IN EXCESS OF THE FAIR MARKET VALUE OF THE SERVICES THEY PROVIDE TO PHYSICIANS, AS WELL AS CONTRACTS WHICH REQUIRE PHYSICIANS TO SPLIT PORTIONS OF THEIR INCOME WITH HOSPITALS. WE FOUND THESE ARRANGEMENTS TO BE HIGHLY SUSPECT.

WE HAVE ALSO EXAMINED THE RANGE OF DRUG PROMOTION PRACTICES THAT INVOLVE PHYSICIANS RECEIVING MONEY OR OTHER ITEMS OF VALUE FROM PHARMACEUTICAL COMPANIES. IN A RECENT REPORT ENTITLED "PROMOTION OF PRESCRIPTION DRUGS THROUGH PAYMENTS AND GIFTS", WE ASSESSED THE VULNERABILITIES SUCH PRACTICES PRESENT, AND EXAMINED THE RESPONSES OF GOVERNMENT AND PRIVATE GROUPS TO INAPPROPRIATE OR ILLEGAL PRACTICES. WE FOUND THAT PHARMACEUTICAL COMPANIES OFFER

MONEY AND OTHER ITEMS OF VALUE TO PHYSICIANS FOR A RANGE OF PURPOSES, FROM SPONSORING IMPORTANT EDUCATIONAL ACTIVITIES TO ACTIVELY PROMOTING THEIR PRODUCTS. THESE PROMOTIONAL PRACTICES APPEAR TO AFFECT PHYSICIANS' PRESCRIBING DECISIONS. ACCORDINGLY, WE ARE CURRENTLY INVESTIGATING KICKBACK CASES INVOLVING PROMOTIONAL PRACTICES OF PHARMACEUTICAL COMPANIES.

CONCLUSION

CAREFUL MONITORING OF THE HEALTH CARE INDUSTRY IS VITAL BECAUSE THE MONEY INVOLVED IS SUBSTANTIAL, THE POTENTIAL FOR ABUSE IS SIGNIFICANT, AND THE NEED FOR QUALITY CARE RENDERED EFFICIENTLY IS ESSENTIAL. FRAUD SCHEMES WEAKEN THE ESSENTIAL PUBLIC BENEFITS WE EXPECT FROM ALL HEALTH CARE PROVIDERS. HOWEVER, WE BELIEVE THAT OUR EFFORTS ARE A MAJOR STEP IN REDUCING THESE ABUSES AND ASSURING QUALITY HEALTH CARE FOR ALL PATIENTS IN NEED OF SUCH CARE.

THIS CONCLUDES MY PREPARED TESTIMONY. WE SHALL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Mr. DINGELL. Thank you very much, Mr. Morey.

Mr. Simon, do you have any comments you would like to add to the statement by Mr. Morey?

Mr. SIMON. I don't, Mr. Chairman, but I am prepared to answer questions as well as Mr. Morey.

Mr. DINGELL. Thank you.

The Chair will now recognize the member from Virginia, Mr. Bliley, the ranking minority member for questions.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Morey, what is the role of the Inspector General in certification, recertification and oversight of the State Medicaid Fraud Control Units?

Mr. MOREY. Well, our responsibilities are definitely of an oversight function. We have the responsibility to not only fund the Medicaid Fraud Control Units but during our periodic recertification process we visit the units in the States and see whether or not the activities there are up to the standard that the legislation has called for.

After our review, if we deem that they are appropriately handling their activities, then we recertify them for another year.

Mr. BLILEY. How often do you actually do this?

Mr. MOREY. We are on site, Mr. Bliley, maybe eight or nine States per year. If we find that a State is in a risk area, we will revisit them more frequently, but I think it is safe to say that we are in all the States at least every 3 years. Some of the States that have more of our funding we have got the recertification process down to where we would visit them yearly, so it varies on the States.

Mr. BLILEY. According to the size?

Mr. MOREY. It is according to the size, yes.

Mr. BLILEY. So you would visit, say, a State like California or New York more often than you would, say, Delaware or Wyoming?

Mr. MOREY. That is true. The State of New York is our largest grant, and we find ourselves there almost every year.

Mr. BLILEY. A critical element in insuring the MFCU's successful investigations of Medicaid fraud is the referral of potential cases by the Medicaid unit. However, an October, 1989, OIG report entitled, Referrals by Medicaid Agencies to Fraud Control Units documented several problems with the referral process which could allow fraud to go undetected or prosecuted. What has been done to correct these deficiencies?

Mr. MOREY. Well, that process calls for the Medicaid Fraud Control Units to not have to look for cases themselves. They would have the SURS Unit, that is the surveillance and utilization subsystem, to detect the fraudulent activities through their claim processing system and then forward the fraudulent claims or the activity that they deemed to be fraudulent to the unit, and then the unit would conduct the investigation.

What we found was that probably wasn't working as effectively and efficiently as it should. In a substantial number of the States it was more of a claims-paying system more than a detection of fraud.

We have held several conferences, have visited the SURS units, and believe they have increased their activity in this area to the point where we think that is now turned around. A majority of the

States that we recertify as we go out and do those recertifications are forwarding good cases to the unit for investigation.

We think that has turned around. It probably isn't perfected 100 percent, but it certainly is in the right direction.

Mr. BLILEY. One of the larger Medicaid fraud problems is that of prescription drugs abuse. On page 5 of your testimony you discuss a computer software package entitled, The Medicaid Abuseable Drug Audit System, MADAS, capable of identifying physicians, pharmacies and recipients that deal in abnormal quantities of prescription drugs with a high street value and categorizing and prioritizing the identified targets. Has this software program been successfully implemented?

Mr. MOREY. Yes, it has. We have successfully implemented that in about nine States. We have another probably nine or ten that are actively looking at it to see whether or not it is compatible with their own system, and we have sent encouraging letters to all the States to look at this program to see whether or not they would be interested in accepting it.

We think it is a good program. It has yielded results. We have three or four States now currently working cases that have been generated from this program.

Mr. BLILEY. Can you give us any idea how much money has been saved as a result?

Mr. MOREY. As far as the actual dollars and cents, it is a little early to determine that. We do have activity here in the District. Virginia is using that system and so is Philadelphia. Current cases are ongoing and as far as the dollar, I don't have the exact figure for you.

Mr. BLILEY. Well, I am glad to see my State is using it.

A key line of defense in identifying and correcting Medicare provider fraud and abuse are the Medicare contractors who process and pay Medicare Part B claims. Contractors' primary source of information or possible provider fraud and abuse are the beneficiaries.

However, a recent GAO report entitled, Medicare—Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse, documents that many contractors miss opportunities to uncover and stop waste, fraud and abuse through the mishandling of beneficiary complaints. Has OIG looked into these problems?

Mr. MOREY. That has been a continuing problem for the last several years, Congressman. The answer is, yes, we have looked into that. We are concerned about it.

What we have come to realize is that there are certainly some contractors out there who do a yeoman's job in looking at their claims and referring them to the OIG, while there are other contractors that are not so diligent. Some of that falls in the area of paying claims, that they are more geared to the payment of claims processing versus the detection of fraud.

We have spent a lot of time and effort working with the Health Care Financing Administration to have them increase their standards so that in their CPEP standards that they would then encourage the contractor to develop more of their resources to the detection of fraud.

Mr. BLILEY. Thank you.

I see my time has expired. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman.

The gentleman from Georgia.

Mr. ROWLAND. Thank you, Mr. Chairman.

Mr. Morey, you stated that last year alone the OIG completed 2348 successful criminal prosecutions and administrative sanctions, of which about 50 percent were health care fraud. How does that number compare with previous years?

Mr. MOREY. If we went back 10 years to 1981 on our sanctions, we sanctioned about 30 health care providers. Last year we sanctioned 1,005. The increase has been so substantial that it is hard to keep up with, from 30 to 300, 400, 800. Now it is up to 1,000. The numbers of criminal convictions have increased from around 30 a year up to about 163. This year we will have about 163 convictions.

Mr. ROWLAND. Do you see any changes in the type of fraudulent activities or in the types of people who are engaged in them now compared to before?

Mr. MOREY. You know, we always look for trends, but I think the answer is that we see no trend in any one area. If we look at durable medical equipment suppliers, we can find fraud cases. If we look at ambulance companies, we will find fraud cases. Certainly, as we look at doctors and other practitioners, we find more of a scattering in all areas versus one element of the health care providers that are doing fraudulent activities.

Mr. ROWLAND. The State Medicaid Fraud Control Directors report the majority of the cases that they won in court involve white collar criminals. Specifically, 47 percent were physicians, 10 percent with pharmacies, 10 percent nursing homes, and 6 percent were corporations of different sorts. Are these numbers about like those that the OIG has found?

Mr. MOREY. Yes, I would say that those are about the same for us.

Mr. ROWLAND. Do you have any—I guess this is a philosophical kind of a question, but do you have any idea of why there is this tremendous increase in fraud? Take, for example, a physician who makes a good income. What is it that, in your opinion, incites them to become involved in fraudulent activity?

Mr. MOREY. Well, there is certainly a lot of money in the health care areas, and there is certainly a lot of opportunities for fraudulent activities. There are also a lot of opportunities through the lack of regulations, I guess, that would allow someone to overutilize and overcharge.

I guess the definition of what a service is worth to one physician is different than another. As you take a look at the durable medical equipment industry, they always seek to bill for the highest price that they can get. I guess it is the greed factor. We pushed the system to the point of what will they reimburse us for, and in some areas it becomes unreasonable. They are so significantly out of balance that the fraud is just there.

If you can bill for something for $20 and get away with it, all right, but what if you could bill for $200, and they will still pay the claim? I think that is what we are finding, that, in fact, when they submit the bill for $200 or $400, we are still paying the claim.

Mr. ROWLAND. Does the system itself tend to encourage that kind of activity, do you think? Where an individual may not under usual circumstances exhibit that kind of greed, but the system in some way incites them to become involved in that kind of fraudulent activity?

Mr. MOREY. Well, I think that is true. I think we have left the door wide open in a lot of these areas, and we have tried to close it by physician fee schedules, and we have done it through the DRG's with the hospital billings. But in a lot of areas we have not put a ceiling on what we will pay for these, and the ceiling just continues to escalate. It is certainly higher than our inflation rate.

Mr. ROWLAND. So we are not just dealing with some isolated doctors here and there, but rather a medical industry that operates much as any other business would and then this tendency to get involved in this kind of activity comes about?

Mr. MOREY. I think that is true, and I think that certainly we don't talk about all health care providers, being involved in fraudulent activities, because they are not. But for those that are inclined to seek the highest reimbursement rate, like I said, the door is open for them to go through it.

Mr. ROWLAND. It appears that the universe that you have to try to police is almost impossibly large, and it seems to be growing still. How many people does the OIG have who exclusively do health care fraud?

Mr. MOREY. Well, in my office there are 460 of us, but if we count just who are doing health care fraud, it is about 220. Certainly that is a sensitive area. We could not cover all the potential Medicaid cases or Medicare cases that are out there with a staff of that size.

Mr. ROWLAND. My time has expired, but I want to follow up with one question. I don't want to lose this train of thought.

That being the case, how do you go about prioritizing the cases that you pursue, either for prosecution or administrative sanctions?

Mr. MOREY. Well, we certainly do have a priority list. If the U.S. Attorney is interested in it, we are going to work the case. If he is not interested in it and there is some money through the Civil Money Penalty Remedies Program, then we are going to work the case because there is a potential to get some recoveries back for the government. Last year we had $26 million recovered through the Civil Money Penalty Program.

Mr. ROWLAND. OK. Thank you.

Thank you, Mr. Chairman.

Mr. DINGELL. The time of the gentleman has expired.

The gentleman from Oregon.

Mr. WYDEN. Thank you very much, Mr. Chairman.

Mr. Morey, it is good to see you again. It is my understanding that the IG is now investigating a very large home care provider, one that may have been involved in paying kickbacks to doctors and overbilling under Medicare. Is that correct?

Mr. MOREY. Yes, it is.

Mr. WYDEN. Is this one of our largest and oldest home care providers?

Mr. MOREY. Mr. Wyden, I don't know how old that case is, but are we talking about the industry now or are we talking about that case?

Mr. WYDEN. What I want to find out is whether this is a big, significant company in the home care field.

Mr. MOREY. Oh, absolutely. It is one of the major companies.

Mr. WYDEN. Without prejudicing the investigation, can you identify that company at this time?

Mr. MOREY. Well, I think we can. It has certainly been in the papers. Mr. Simon here is the head of my criminal investigating division. Why don't I give him the opportunity to tell you what he can about that case?

Mr. WYDEN. I would like to know about the case, and, of course, I want to have information about this that is not going to prejudice your inquiry.

Mr. SIMON. Surely. I think the company you are asking about, Mr. Wyden, certainly is Caremark, the largest infusion supplier in the United States.

I don't really feel at liberty to go into the nature of the allegations, but I will tell you that Caremark themselves have confirmed that they are under investigation, that we have served a subpoena, and they have publicly stated that one of the avenues of inquiry for us is whether referrals—whether fees paid to physicians by Caremark are legitimate or are they, in fact, thinly disguised kickbacks for referrals.

This infusion industry relies very heavily on patients, and those patients have to come from somewhere. It is a major vulnerability in that industry, in my view.

Mr. WYDEN. One of the things that I have been most interested in and why I think Chairman Dingell's inquiry is so important is that it always seems that these questionable characters are looking to get one step out in front of today's strictures and today's regulations, and there are certain things that you always look for in terms of trying to figure out where the buccaneers and these sleazy operators are going to be next, and one of them that obviously comes to mind is just a general lack of regulation.

Do you generally think—and this doesn't go to your comment about Caremark at all—do you generally think that the home care field is a fertile target for questionable operators in the years ahead because there is an overall lack of regulation in the home care field, Mr. Simon?

Mr. SIMON. I think that the home therapy industry is new. It has emerged in recent years, and it is ahead of the regulatory process.

Lack of regulation, I would say, is lack of definition—what clearly are defined as the services that they provide. We have seen in this and other industries that suppliers, for example, medical suppliers, equipment suppliers, will come along with a new piece of equipment, bill it for many hundreds of dollars when to us clearly it is just a piece of cotton cloth with a couple of plastic attachments to it.

A good example pops into my mind, a device called a torso restraint, and that is really just a piece of cloth that stretches across the chest of a wheelchair-bound patient to keep that patient from falling out of the wheelchair. A torso restraining device sounds like

an esoteric piece of medical equipment, and the carriers have paid up to hundreds of dollars for each one of these things. I think you could probably make one at home for about $3.98.

So that goes along with your train of thought, I think, Mr. Wyden.

Mr. WYDEN. So you would say that the home care field is likely to be a fertile target for finding fraudulent practices in the years ahead?

Mr. SIMON. I would suggest that that is true.

Mr. WYDEN. If you could be a little more specific. Are they liable to be billing practices, kickbacks and the like? Are they liable to be quality of care problems? What are the areas that we should be most sensitive to in these upcoming years in home care?

Mr. SIMON. I would say there are two areas. One is the area of cost restraint. There are exorbitant markups in this. I think Medicare along with private insurance payers are paying an exorbitant amount for the service that we are getting.

As I mentioned earlier, this kind of business is dependent on a steady stream of patients, and it is a highly-competitive business. These operators will compete for these patients in any way that they can.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman.

The gentleman from Minnesota, Mr. Sikorski.

Mr. SIKORSKI. Thank you, Mr. Chairman.

Mr. Morey, in 1989 the OIG conducted a study that examined the effect of physicians' involvement in joint ventures of various types. What you found at that time was that doctors who own labs perform 40 percent more tests than other labs, that doctor-owned diagnostic imaging labs, those doing CAT scans and MRI's performed 12 percent more than non-physician-owned facilities, and that durable medical equipment was prescribed 16 percent more in doctor-owned facilities and all those additional or excessive services were all billed to Medicare, isn't that right?

Mr. MOREY. Yes, that is true.

Mr. SIKORSKI. Did your study also find that poor quality was a problem in these facilities?

Mr. MOREY. Yes, it did.

Mr. SIKORSKI. Your study looked at eight States and limited the review to those three types of services or products, isn't that correct?

Mr. MOREY. Yes.

Mr. SIKORSKI. They need to get the yes there. The chairman often reminds there is not a nod button on the thing.

Just 2 months ago the Florida Health Care Cost Containment Board reported on the findings of a new study conducted for them by Florida State university economists and business management researchers. They examined 2200 clinics and other health care businesses. Among their findings were that nearly half, half the doctors in Florida have invested in joint ventures of one type of another.

Based on your earlier review, are you surprised by that number?

Mr. MOREY. A little bit, yes.

Mr. SIKORSKI. It is unusually high?

Mr. MOREY. Right.

Mr. SIKORSKI. These findings subsequently have been voted on, approved by the Florida Board. That study found further that doctor-owned joint ventures were used more frequently, used less skilled workers and offered limited access to the poor. Are those findings consistent with your investigation in 1989?

Mr. MOREY. Yes, they are.

Mr. SIKORSKI. The Florida study identified three types of health care businesses in which joint ventures were most prevalent—clinical labs, diagnostic imaging and physical therapy centers. Again, do those conclusions reflect those of the OIG?

Mr. MOREY. Yes, they do.

Mr. SIKORSKI. Florida—now, New York State has also had problems with doctor-owned home care businesses. Mr. Kuriansky will be talking to us about what trends they are seeing there. Have you seen an increase in doctor ownership in those businesses and corresponding trends in billing and quality as well?

Mr. MOREY. Yes, all of the above. What you are saying we are in agreement with.

Mr. SIKORSKI. The study also found that doctor-owned facilities are likely to charge considerably more than non-doctor-owned facilities for the same services. For example, lab tests that cost $20 in non-joint venture operations cost $43 in doctor-owned joint venture labs. Did your study identify the same problems?

Mr. MOREY. Yes.

Mr. SIKORSKI. The Florida researchers also found that, and I quote, "almost twice as many diagnostic tests," were done per patient in doctor-owned facilities. This theme of overutilization and overpricing is consistent with the OIG's earlier research, isn't that correct?

Mr. MOREY. Yes.

Mr. SIKORSKI. The Florida study reported a significant growth in doctor-owned facilities over the last 5 years. Do you see that same thing occurring?

Mr. MOREY. Yes.

Mr. SIKORSKI. What do you believe is the cause of those trends?

Mr. MOREY. If we talk to the medical community, they will tell you that if they are going to invest in a laboratory, that they would be the ones that would be the investor because they have an interest, and they have the knowledge and the expertise.

When we review that situation, we say if you are a doctor and you have an investment in something, then you are going to overutilize it, and our studies and the report that you indicate there confirm that.

When we take a look at the demand for health care and we take a look at the hospital consolidation and you take a look at laboratories that have consolidated and new ones that have sprung up, that whole system network forces the health care physician to become an investor. He wants to invest in that. He thinks he can offer better service, and I think that is what we have. We have the economies of America here at work.

Mr. SIKORSKI. Well, as I understand it, one of the arguments made by the doctor-investor is that they, pooling capital, bring the services that wouldn't be available to their clients, their patients.

What we are hearing in response is it comes down to there is very little regulation, effective regulation that prevents this, and there is a big profit out there to get involved in this. Is that what you are seeing?

Mr. MOREY. Well, I think that is true. If you are familiar with the Safe Harbor statutes, you will see that one of the elements of that Safe Harbor is it controls the amount that the physician or the health care provider can invest in the joint venture at 40 percent. It also controls the amount of referral of revenue from a hospital, if it has made a joint venture with a physician. So it forces you to go outside that hospital and have 60 percent of the referrals and revenues come from someone else.

Mr. SIKORSKI. In light of this thing, these findings, your investigation, is it the OIG's position that joint ventures be banned to guard against abusive and fraudulent billing practices and quality problems?

Mr. MOREY. I am not so sure about the word banned. We certainly realize that there is going to be a certain amount of joint ventures in our country. We think there can be a certain amount that can operate and function appropriately, but we also know the red flags are up because it generates referrals and it generates overutilization.

Mr. SIKORSKI. Would it be fair to believe that these kinds of things be severely, substantially, significantly restricted so to eliminate the excess billing, the excess use and the quality issues altogether?

Mr. MOREY. I think that is true, Congressman. We ought to do that.

Mr. SIKORSKI. Thank you.

Thank you, Mr. Chairman.

Mr. DINGELL. The time of the gentleman has expired.

The gentleman from Michigan, Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman.

I appreciate your testimony this morning. I have just a couple of questions. Several entities share responsibility for oversight of Medicare, including HCFA, of course, Medicare contractors, and the OIG. In order to insure effective oversight and protection for Medicare and its beneficiaries from fraud and abuse, I know you need to have close cooperation among these entities, and I wonder what the OIG has done to insure that type of cooperation. Could you come up with some examples?

Mr. MOREY. I certainly know we spend a considerable amount of time at the OIG working with HCFA. We generate management implication reports when our agents find a problem in the system. Rather than just obtaining a conviction or getting some money back for the government, we look at how we can plug up the loophole.

When that report comes through, we take those to HCFA and ask them if they would take the suggestion of this street agent to patch up the system. So there is a lot of cooperation as it comes back and forth from input from our field.

We also generate fraud alerts, which tells HCFA that we have got this problem. It puts other people on notice that if we don't plug up this loophole, we are going to have further problems, so be-

tween management implication reports, fraud alerts, training, liaison, we seem to be covering a lot of our bases. They are probably not perfect, but they are being worked on.

Mr. UPTON. You referred a few minutes ago to the Safe Harbor regulations, and I know that the Medicaid Patient Program Protection Act of 1987 authorized OIG to impose civil monetary penalties and to exclude from Federal health care programs those who violated the anti-kickback statute, and the 1987 law also required the Inspector General to issue the regulations which were issued, it is my understanding, late July of this year.

What type of abuses will these regulations prevent and what are the content of those regulations? Also, and it may be too early to tell or to give some examples of some of the benefits which have accrued since then—if you can give me some examples of that?

Mr. MOREY. Well, certainly, the whole area of kickbacks of the Safe Harbor regulations were long in coming, it took a long time to get the regulations out. A lot of cases that we may have worked, we held in abeyance until the regulations were out.

You are probably familiar with the Hanslester ruling which just came out. We had an administrative law judge who put on more restrictions than we thought were necessary. Through an appeal, that was overturned. So, in essence, I think we are off and running in the Safe Harbor regulations. I don't think the Safe Harbor regulations will generate a tremendous increase in the number of kickback convictions.

Fact of the matter, it may have the opposite effect. If you take a look at what could be a Safe Harbor, there definitely is no Safe Harbor case law. It takes a lot of work to get into one. We have a lot of the medical community now complaining they are too strict. Certainly time will tell, but I would imagine that by this time next year we will probably have something positive to report if the Safe Harbors will impinge on our work or help us.

Mr. UPTON. Thank you. I yield to you, Mr. Chairman.

Mr. DINGELL. The Chair notes there is a vote going on on the Floor at this time. So it will be necessary for the committee to recess briefly to go to the Floor. I would anticipate that we would be back here about 11:15, so we would adjourn, then, to give us enough time to get over and get back at 11:20, and at which time members again will be recognized.

Mr. Morey and Mr. Simon, I want to thank you for your very valuable assistance to the committee. We will have you back for further questions at that particular time. Thank you, gentlemen.

[Brief recess.]

Mr. DINGELL. The subcommittee will come to order.

Mr. Morey, the Chair thanks, again, you and Mr. Simon, for your very valuable assistance to the committee. You and the Office of Inspector General have been extremely helpful to this subcommittee in identifying fraudulent activities and serious quality problems in laboratories and clinical laboratory testing.

As you know, the subcommittee has an ongoing investigation into HCFA's failure to implement the Clinical Laboratory Improvement Amendments of 1988, CLIA. Your testimony strongly suggests that lab fraud and attendant quality problems continue to be a major source of multimillion dollar fraud in this country.

There is a continuing absence of regulations to implement the continued and considerably beefed up statutory authority, inhibiting the ability of the Office of Inspector General, and the Department of HHS, generally, to go after the lab fraud and to address associated problems.

Mr. MOREY. Mr. Chairman, I think generally if we have good regulations and statutes and people can read and understand them, that helps the system. And I think when we have something languishing, it slows the system up. So I think the obvious answer is, yes, we need those, and when we would get them, it might smooth out the system.

Mr. DINGELL. You mentioned four types of fraud that involves labs. One was the so-called sink testing, literally throwing out the tests and reporting purely manufactured results. Do the current mechanisms for reviewing laboratories' activities at HCFA help identify laboratories doing sink testing?

Mr. MOREY. Well, I think sink testing was more prominent in years past. We have run into a few cases of that. It is certainly not as frequent as in the past. I think HCFA has helped us. Certainly, the carriers detect a few of those, yes.

Mr. DINGELL. But in point of fact, the current laboratory regulations do not do much to assist in identifying either those who engage in sink testing or bringing the practice to a halt; do they?

Mr. MOREY. No, they don't.

Mr. DINGELL. In fact, the only way you can deal with this, is if you at OIG or at HHS or somebody gets a tip or if you or somebody at OIG was actually in the laboratory and saw that the lab didn't even own the equipment to conduct the test for which they billed, is that correct?

Mr. MOREY. That is certainly one way to solve that. If you didn't have somebody on the inside who is saying he was pouring those specimens down the sink, you would have to have a documented case where the person never used the lab.

Mr. DINGELL. But without it, it would be almost impossible to identify people engaged in sink testing or address the problem or make a case against them, is that right?

Mr. MOREY. That is true.

Mr. DINGELL. Other lab scams involved doctors doing unnecessary testing and excessive billings for the tests they did do. These, again, are enormously difficult kinds of cases to go after, are they not?

Mr. MOREY. Yes, they are.

Mr. DINGELL. CLIA 1988 specifically extended the law to cover labs in doctors' offices, but it doesn't really help in identifying the kind of fraud that we are talking about here; does it?

Mr. MOREY. No, it doesn't.

Mr. DINGELL. Now, once again, we are left with having to rely principally on tips to produce these kinds of cases, are we not?

Mr. MOREY. That is generally the way. Either that or through some type of kickback situation where you would work into it.

Mr. DINGELL. Now, in the case, however, of excessive billings, the department could look at HCFA and carrier billing codes, could they not?

Mr. MOREY. Yes, they could.

Mr. DINGELL. But those are enormously complicated?

Mr. MOREY. Yes, they are.

Mr. DINGELL. It would be very hard to make a case or explain those matters to a jury, would it not?

Mr. MOREY. I think that is true. I think it would be.

Mr. DINGELL. Does the absence of specific guidelines and criteria clarifying what is overutilization and unnecessary testing hamper your ability to prove wrongdoing in these kinds of case?

Mr. MOREY. Well, I think that is right. Whenever we don't have solid regulations, then you would lose one element of intent. You wouldn't be able to convince a prosecutor that the person intended to defraud the statute if we didn't have the statute in regulation.

Mr. DINGELL. Now, you testified that the Office of Inspector General has previously proposed rolling in lab services with office visits. I believe this is something that should be considered. But on the one hand, what seems to make sense doesn't on the other, and I refer specifically to the fact that it would pose the kinds of problems that perspective payments do in that providers could take the opportunity to cut back on services and still get the same or more reimbursement, is that correct?

Mr. MOREY. Well, it is certainly a possibility. I guess every system can work both ways.

Mr. DINGELL. So we have got a problem that requires some rather careful focus if we are to address successfully?

Mr. MOREY. I think that is true. We made a suggestion that maybe a doctor should write a prescription for durable medical equipment rather than rely upon the seller to coerce the patient into saying that he needed this. So now we would have a medical doctor writing prescriptions for medicine, and writing the prescription for durable medical equipment. Now we are suggesting that with his office fees, he would have a certain amount of moneys built in there for lab testing.

And your point is well taken, if the doctor kept the money and didn't do the lab examination, we would defeat our purpose. It may work the opposite way, though, and the physician may be ethical and we are in hopes that the vast majority of them are. And would request the right laboratory testing and we may save money.

Mr. DINGELL. One of the good tests of how a statute is working is, of course, the number of prosecutions or the drop in the level of misbehavior determined statistically, or in the amount of civil and criminal penalties collected.

Can you tell us how much has been collected in civil and criminal penalties under CLIA since the passage of the new law in 1988?

Mr. MOREY. Do you happen to know that information?

Mr. SIMON. Mr. Chairman, the figure that we have, is almost 50 convictions, criminal convictions and civil actions in laboratories over the last 5 years. I can't connect a dollar figure with it at this moment for you.

Mr. DINGELL. Would it be fair to say that absolutely nothing has been collected in civil and criminal penalties under CLIA and that any penalties, civil or criminal, which would have been collected would have been collected under other statutes?

Mr. SIMON. Under our general enforcement statute, is what I was referring to. Under CLIA, I think zero is the correct number.

Mr. DINGELL. Sir, actually zero?

Mr. SIMON. Yes.

Mr. DINGELL. It is HCFA's responsibility to prove civil penalties and to identify the criminal violations, then refer them to you; isn't that correct?

Mr. SIMON. That is generally so, yes.

Mr. DINGELL. So I guess it would be fair to say that HCFA has recovered very little, if any, money from fraudulent lab practices that were identified and prosecuted over the 3 years in question, is that right?

Mr. SIMON. That is correct, Mr. Dingell.

Mr. DINGELL. How many cases under CLIA have been referred to the Inspector General's office by HCFA?

Mr. SIMON. The answer is none.

Mr. DINGELL. None.

HCFA also has the authority to stop the operation of a laboratory, either for fraudulent practices and activities or for poor quality, isn't that right?

Mr. SIMON. Yes.

Mr. DINGELL. Now, how many times has HCFA closed down a laboratory in the last 3 years because of either excessive billing, fraudulent activities or poor quality work?

Mr. SIMON. Not aware of any, Mr. Dingell.

Mr. DINGELL. Not aware of any.

How many times has HCFA tried to impose an injunction tc stop a laboratory from performing, for example, pap tests that could pose significant risks to patients?

Mr. SIMON. Again, I am aware of none.

Mr. DINGELL. Now, if a bad laboratory test is done, for example, in a pap test, and you get, let's say, a false negative, what is going to happen to the woman who has received that joyous news of a false negative?

Mr. SIMON. In the worst case, obviously, undetected cancer.

Mr. DINGELL. So that false negative and pap test identifies a woman who shows no evidence of cancer or cancerous symptoms, isn't that right?

Mr. SIMON. Yes, sir.

Mr. DINGELL. And she is, thereby, deterred from pursuing further a course of treatment which would either prevent the cancer or to enable it to be addressed, either surgically, clinically or through radiation, to eliminate a major life threatening condition; isn't that so?

Mr. SIMON. That is so.

Mr. DINGELL. I recognize this is not your specific responsibility—I may have the Secretary before us to discuss it—how does this HHS justify this failure to address just this one single question involving a serious risk of death or something similar to a potential or real cancer patient?

Mr. SIMON. Well, as you have observed, Mr. Chairman, that is not really our field.

Mr. DINGELL. It is not your responsibility. Is there any policy statement in the Department as to why they are not engaged in a more vigorous pursuit of this kind of situation?

Mr. SIMON. I think that is a matter to be answered, a question to be answered by HCFA and the Public Health Service.

Mr. DINGELL. I think we can both anticipate that we will be hearing from them in the proper order of things.

Mr. SIMON. Hope so.

Mr. DINGELL. Are there further questions for the witnesses?

Gentlemen, the committee has worked with the Office of Inspector General and we have found you to be fine public servants. You have, again, proven that to us today. We thank you for your assistance and for your very valuable testimony. We thank you very much.

The Chair notes that our next panel is a panel composed of Mr. Jan Koppelnick of Baltimore, Maryland, and Mr. Edward Kuriansky, Deputy Attorney General and Special Prosecutor for Medicaid Fraud Control, State of New York.

Gentlemen, if you would please come forward, we would be delighted to hear your testimony.

The Chair notes Mr. Koppelnick is accompanied by Mr. Daniel R. Anderson, Deputy Chief, Medicaid Fraud Control Unit, Office of the Attorney General, State of Maryland, Baltimore, Maryland.

Gentlemen, you are all welcome and we thank you for your assistance to the committee.

Gentlemen, the Chair advises that it is the practice of the committee that all testimony is received under oath. Do any of you have any objection to testifying under oath.

Mr. KOPPELNICK. No.

Mr. ANDERSON. No.

Mr. KURIANSKY. No.

Mr. DINGELL. The Chair advises you that if you testify under oath, it is your right to be advised by counsel. Do any of you desire to be advised by counsel during your appearance here today?

Mr. KOPPELNICK. No.

Mr. ANDERSON. No.

Mr. KURIANSKY. No.

Mr. DINGELL. Gentlemen, the Chair advised you that for your assistance in understanding the rules of the committee for you to better understand your rights and also the limits on the powers of the committee, copies of the rules of the committee, the subcommittee, and the House are there at the witness table to advise you.

Gentlemen, if you have no objection, then, to testifying under oath will you each please rise and raise your right hand.

[Witnesses sworn.]

Mr. DINGELL. Gentlemen, you are welcome. The Chair has a bit of administrative business to address at this moment.

The Chair does have a brief 5-minute film presentation that the Chair would like to have made available to the committee and to the audience at this particular time, so if staff will please start the machine rolling, then we will address the questions.

Without objection, the transcript of the audio portions of the film will be inserted in the record.

[Testimony resumes on p. 69.]

[The transcript follows:]

RPTS GARLAND
DCMN GALLACHER
ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
THURSDAY, OCTOBER 10, 1991

TRANSCRIPT OF VIDEO FILM OF CHANNEL 2 NEWS SPECIAL REPORT

Mr. TAIBBI. You see them everywhere, in depressed neighborhoods, all five boroughs, lines of people on sidewalks, in hallways, in waiting rooms waiting to see the doctor.

UNKNOWN SPEAKER. Mr. Martinez, Jonathan, Christine, Christian, Alphenia, Alexa.

Mr. TAIBBI. But while some of these people may have medical problems, many are showing up at these doctors' offices and clinics, sometimes even before daybreak, for medical treatment. They come for prescriptions, for expensive noncontrolled drugs and other pharmaceutical products. They know that if they got an authentic medicaid card they will find a doctor to write the prescriptions, or script as it is called, and a pharmacist to fill it and that they will end up with a bag of goods that is less risky to obtain than controlled drugs, like Valium or codeine, but it is just as easy to sell.

UNKNOWN SPEAKER. He gives me Zantac, Procardia 7, Duricef 500. That is $45.

Mr. TAIBBI. For the medicaid card holder, it is money. Small money but easy money to buy street drugs or whatever. For the doctors and pharmacists who play, it is easy money, too, but huge money. Hundreds of millions of dollars each year for goods and services never delivered to medically needy patients.

On the street the scam is called ``playing doctor,'' and we know how it works because producer Anna Phillips and cameraman Tracy Emory played doctor for weeks in clinics and doctors offices and pharmacies in three boroughs.

UNKNOWN SPEAKER. All you got to tell them is that you got back pain, a chest infection, ulcers, asthma, and sinus. You got to do those five.

Mr. TAIBBI. A long-time player explained the rules. The grapevine provides the names of the doctors and all you give the doctor is a photo I.D. and your medicaid card and a list of the right symptoms.

UNKNOWN SPEAKER. Does the doctor know what you are doing?

UNKNOWN SPEAKER. The one I went to yesterday, yes, he did.

Mr. TAIBBI. The players have no trouble finding doctors willing and eager to play themselves. After all, for simply writing out prescriptions the doctors get to claim new

patients and to bill medicaid for treatment never given.

UNKNOWN SPEAKER. This is your first visit, you are good to go [inaudible]--

Mr. TAIBBI. You get your prescriptions, as an NA did several times, and your next problem is to get it filled. The street term, to bust the script. The lines form outside the pharmacist known to play and during the waiting period, the guy who will later buy your bag of goodies sometimes stops by to offer some guidance.

UNKNOWN SPEAKER. Hold on. No, you don't have to go that far. Trust me, okay, 105 East 115th Street, Broadway Pharmacy. They just opened up. Tell them Peggy sent you over there.

UNKNOWN SPEAKER. Tell them Peggy sent you over there?

UNKNOWN SPEAKER. I am trying to tell you now. They take everybody's script when they just open up.

PHARMACIST. We don't take that doctor.

UNKNOWN SPEAKER. Peggy told me it was cool.

Mr. TAIBBI. At the Broadway Pharmacy they wouldn't fill Anna's script until she said, Peggy sent me, then it was all smiles; $185 worth of goodies plunk into a bag, and then it was time to see the man who called himself Twin and said he was Peggy's husband. Twin is a new kind of dealer on the street who buys and sells prescription noncontrolled substances, thus who is called the NC, or nonman.

UNKNOWN SPEAKER. Birth control is $3, this is four, that is seven. And what did he give you, 20 Seldane?

Mr. TAIBBI. Twin paid Anna $22 [inaudible]--

Mr. TAIBBI. Now, two other dealers and one pharmacist told us about the threat to your health posed by this scam. They say some pharmacies are bankrolling street dealers to buy back the same drugs Medicaid just paid for so they can be dispensed again, maybe to you.

Tonight at 11:00 in my next report we will take a hidden camera look at one doctor's operation. You will be shocked by what you see and what you hear.

ANCHOR PERSON. See you tonight at 11:00, Mike.

ANCHOR PERSON. Tonight in News Scam in New York is jeopardizing your health care and ripping off your tax dollars. On the streets it is called ``playing doctor.``

ANCHOR PERSON. We call it a prescription for danger, and as Channel 2`s Mike Taibbi first revealed on Channel 2 News at 6:00, it involves real doctors, pharmacists, and unscrupulous medicaid card holders.

Now, in a new exclusive report, Mike takes us undercover to expose one doctor`s operation.

UNKNOWN SPEAKER. Bad news.

UNKNOWN SPEAKER. What, no doctors today?

UNKNOWN SPEAKER. No doctors there?

UNKNOWN SPEAKER. No doctors today? Are you serious? Told me to come over and tell you all.

Mr. TAIBBI. It is a laughably easy game for the people who want to play doctor, people who regularly trade their status as medicaid card holders for prescriptions written by unscrupulous doctors for expensive noncontrolled drugs and pharmaceutical products, all of it easy to sell on the street for cold cash.

Sometimes as producer Anna Phillips and camerman Tracy Emory found, the annoying heat from medicaid fraud investigators does delay the game for a while.

UNKNOWN SPEAKER. Can`t do one more?

UNKNOWN SPEAKER. We took 20, 25 people. Medicaid was

here today. We weren't supposed to take none. They are coming back.

UNKNOWN SPEAKER. Oh, man.

UNKNOWN SPEAKER. So we trying to do this on the hum [secretly].

UNKNOWN SPEAKER. Any other time you have hundreds of people standing out here.

Mr. TAIBBI. But there are plenty of doctors whose names are on the grapevine.

UNKNOWN SPEAKER. You can try that new doctor they've got, comes in at 12 on 125th Street on Morningside.

Mr. TAIBBI. Doctors willing to write shopping list-style prescriptions so they can claim new patients and bill medicaid for treatment often never given. doctors like Dr. William Capote. In six weeks, he billed medicaid for well over $50,000, much of it for the treatment of patients like these people who crowd Capote's waiting room, not because they have medical problems, but because they want prescriptions they can turn into money.

UNKNOWN SPEAKER. He wrote me Prozac; he wrote me Mevacor; he wrote me Cipro 500. He gave me what I wanted. That doctor is cool.

Mr. TAIBBI. Anna saw Capote for all of five minutes. Someone else had taken her history, which included four problems she didn't have, which included asthma and ulcers.

Capote asked a few questions, gave the most cursory examination, and, bingo, the shopping list: A ventolin pump, Augmentin, Feldene, and birth control pills she never requested; 185 bucks worth in all when the Broadway Pharmacy filled the script, minus two packages of birth control pills, and $22 cash for Anna when the street dealer, the NC, bought the stuff back.

It is short money for the long hours on the hustle, but then crack didn't cost much by the hit, neither the crack being smoked in the Capote's waiting room nor the crack being sold by street dealers who are swarmed by some of the same people who earlier swarmed the doctor's office.

Capote, whose regular practice is on tidy Marspark Avenue in the Bronx was surprised beyond imagining that neither Anna nor some of his other patients weren't really sick.

Dr. CAPOTE. I am unaware of the scam.

Mr. TAIBBI. You are an unwitting part of the scam?

Dr. CAPOTE. I am.

Mr. TAIBBI. But it doesn't work without your signature, and it doesn't bother you now to hear that she has--

Dr. CAPOTE. I am annoyed that people who come up to me with false ailments--

Mr. TAIBBI. Capote told us that he took over the Harlem practice when a lawyer representing that second doctor walled him out of the blue. Capote says he splits his

medicaid fees 50-50 with that second doctor. He says he doesn't know that Tyrone, who runs his office, is also helping to run the scam.

UNKNOWN SPEAKER. There is a problem with Zantac, the high-powered ulcer medication on your script.

Mr. TAIBBI. And I insisted he had no idea that people listing ailments in need of treatment only really needed the prescriptions he wrote, again and again and again.

Dr. CAPOTE. Now, as I see these people coming in asking for medications, which they really don't need, just to get money on the outside.

Mr. TAIBBI. You are shocked?

Dr. CAPOTE. I am shocked.

Mr. TAIBBI. Well, perhaps we should all be shocked, for the game called ``playing doctor`` is costing us millions and millions in medicaid rip-offs and all of it happening because some patients are willing to lie about being ill, some doctors are willing to bill medicaid for treatment never given, and some pharmacists willing to fill prescriptions for people who aren't sick who then bill medicaid for the medicaid goods.

Now, tomorrow at 6:00 and 11:00, in two different reports, we will look at what, if anything, can be done to stop the players from playing doctor.

ANCHOR PERSON. Thanks, Mike.

ANCHOR PERSON. Channel 2 News has learned of a new medicaid scam costing taxpayers millions of dollars and jeopardizing the quality of medical care in New York. On the streets, it is called ``playing doctor.``

ANCHOR PERSON. It works because some medicaid patients lie about being ill, some doctors bill medicaid for treatment never given, and some pharmacists fill prescriptions for the phone-in patients and then charge medicaid for the medicine.

Mike Taibbi first exposed this scam yesterday on Channel 2 News at 6:00, and tonight an undercover look at how this game is played.

Mr. TAIBBI. After a few weeks of playing doctor, producer Anna Phillips and cameraman Tracy Emory pretty good at the game, picking and choosing among the more interesting variations.

This is Hooper Street in Williamsburg, the doctor, who will see Anna, and Anna is using a different name, is a podiatrist named Daniel Diana.

UNKNOWN SPEAKER. Elizabeth Tucker.

Mr. TAIBBI. Now, here is the gimmick in this office. The word on the street is that if you bring your medicaid card to this office you will not only end up with a prescription for the easy to sell bag of noncontrolled drugs and pharmaceutical products, goodies you can conveniently pick

up at the M and B Pharmacy next door, you will also end up with a brand new pair of sneakers.

The word on the street was right on the money. Anna got her bag of goodies and her new pair of Kicks. As to her nonexistent medical problems, how long would you say the examination took?

Ms. PHILLIPS. The examination took all of four minutes.

Mr. TAIBBI. And consisted mostly of a few questions?

Ms. PHILLIPS. A few questions about my medical history, whether I had high blood pressure, if I am allergic to any medications, and do I have pain, do I have various other things.

Mr. TAIBBI. One medicaid card holder in the waiting room told us she did, in fact, have a medical problem. But earlier, when it was only a hidden camera running, the conversations were all about playing doctor, scamming medicaid.

In a way, it is a nearly perfect scam. There is no kind of violence that would attract attention and everybody wins. The physician wins, the pharmacist wins, the phone-in patients win, the NC, or the dealer wins. Everybody wins except you, the taxpayer, and you lose big time.

How big is the bill? The official estimate is that between five and 25 percent of the State's $13 billion annual medicaid costs are fraudulently billed. The M and B

Pharmacy, nothing more than a hole in the wall, billed medicaid $518,000 last year and is on a pace to bill 600 grand this year. The pharmacist wasn't eager to discuss his business.

Don't push me. Please don't push me. Can I ask why you are here?

Dr. Diana, who billed medicaid $205,000 last year and is doing at least as well this year, was in a denial mode. Denying, for example, that his patients were ever given sneakers.

Dr. DIANA. I don't given anything to patients. I write what patients need. I write cream, I write foot.

Mr. TAIBBI. I am sorry, what?

Dr. DIANA. I write cream, foot cream. I write whatever is necessary for patient care.

Mr. TAIBBI. Yeah? Okay.

Dr. DIANA. Okay?

Mr. TAIBBI. Now, do you do a complete examination?

Dr. DIANA. Yes, I do.

Mr. TAIBBI. But his assistant, and not a licensed assistant, by the way, said, oh, yeah, we do give them sneakers.

DOCTOR'S ASSISTANT. Some of the patients that come to us, they don't have the sneakers to wear. They have a torn sneaker. It is some old and junky, so we want the

patients--should be relieved on the basis of the humanitarian ground, we give sneakers.

Mr. TAIBBI. But that is not what Tracy heard during the many hours he spent in waiting rooms just like this one.

Mr. EMORY. People have been playing the game for four or five years and they are working it down to a science. You even hear people saying, I have got it down to a science. I can hit this spot today, I can hit this spot next week, and it gets me the money I need.

Mr. TAIBBI. But a young physician who lives in the neighborhood sees it for what it really is.

This isn't community medicine?

UNKNOWN FATHER. It ain't.

Mr. TAIBBI. What is it?

UNKNOWN FATHER. It is a fraud, really.

Mr. TAIBBI. And if it is really a fraud and it is this widespread and if we and our cameras had no trouble documenting it, why can't those aggressive medicaid fraud investigators put a stop to it. You are not going to like the answers which you will hear in my final report tonight on Channel 2 News at 11:00.

ANCHOR PERSON. Thank you, Mike, and now on to the extremely pleasant topic of our--

PROMO. You are watching Channel 2 News at 11:00, winner of the Emmy Award for New York's best newscast.

ANCHOR PERSON. Channel 2 News has learned of a new medicaid scam costing taxpayers billions and jeopardizing the quality of medical care in New York. On the street, it is called playing doctor.

ANCHOR PERSON. Well, lit works because some medicaid patients lie about being ill, and some doctors bill medicaid for treatment never given, and some pharmacists fill prescriptions for the phone-in patients and then charge medicaid for the medicine.

Channel 2's Mike Taibbi first exposed this scam yesterday, and tonight, in his special report, a look at what can and can't be done to stop it.

Mr. TAIBBI. This scam is about money, taxpayers' money, your money.

The doctors, the pharmacists, and the medicaid card holders involved all know the game, in its present form, is both lucrative and safe. Lucrative because the prescriptions involved are almost always for the more expensive items medicaid will pay for, and safe because those items are not controlled drugs like Valium and codeine, but noncontrolled drugs and pharmaceutical products that are just as easy and not nearly as risky to move on the street through the NC or the nonman, the new specialized

dealer.

Mr. KURIANSKY. You are dealing here in an area which in some respects is beyond the reach right now of the criminal law. These people are not dealing narcotics, they are not dealing controlled substances.

Mr. TAIBBI. So this particular category of medicaid fraud goes on largely unchecked. It starts, of course, with doctors who are willing to write unneeded prescriptions and then billing medicaid for services and treatment in many cases never given.

In one case a patient obtained this prescription without ever even seeing the doctor. We know because the patient was producer Anna Phillips, and while an ethical pharmacist would look at the prescriptions Anna obtained and see a red flag, there are plenty of pharmacists who will fill these prescriptions, billing medicaid, sometimes withholding some expensive items. After all, the medicaid card holders who are playing the game don't want the prescription items, they want the money they fetch from the NC's, the dealers.

And three NCs, including this man, confirmed what the pharmacist told us, that they, the NCs, are often bankrolled by certain pharmacies to buy back for the pharmacies, at pennies on the dollar, the same bag of medical goods they can now be dispensed again.

Mr. KURIANSKY. And they are bankrolled and they are not

only bankrolled, we are learning of late by pharmacies, they are bankrolled sometimes from out of country. They are pairs, we have begun to trace some of these drugs and other supplies going out of State, going out of country, to Puerto Rico, to Colombia, particularly the Dominican Republic.

Mr. TAIBBI. But with successful prosecutions unlikely and, therefore, not pursued, the game goes on. A category of medicaid fraud costing tens of millions, perhaps hundreds of millions of dollars a year.

Kuriansky`s medicaid fraud unit has nailed over 1000 doctors, pharmacists, and other providers in the past five years for other types of fraud. But when she showed him some of our hidden camera tape, he agreed this one is tough to get to.

So the doctors involved offer inducements to attract new patients, the pharmacists remind them there are no new limits on doctor`s visits, prescriptions, or other medical services, and many medicaid card holders, little people in the middle who play the game for a few dollars a day, encourage each other that the game can go on and on and on.

UNKNOWN SPEAKER. It is not drying up, believe it or not. The noncontrolled is going like crazy.

Mr. TAIBBI. We saw it going like crazy all over New York City. When medicaid fraud investigators do manage to get rip-off artists into court, their conviction rate is

spectacular, over 90 percent. But the playing doctor scam presents a special challenge not yet overcome, and staff and budget cuts are coming. No one can say how many millions it has so far cost you, the already overburdened taxpayer.

ANCHOR PERSON. A stubborn and costly problem.

ANCHOR PERSON. A form of medicaid fraud that steals millions of your tax dollars every year. Channel 2`s Mike Taibbi recently exposed this scam in a series of undercover reports called ``Prescription for Danger`` tonight.

ANCHOR PERSON. Tonight Mike begins a special series of follow-up reports by telling us about an illusive king of medical fraud.

Mr. TAIBBI. The man in the driver seat, our investigation shows, has cost you, the taxpayer, tens of millions of dollars and perhaps more. His name is Mohammed Sohail Kahn, who with his relatives and friends, our sources say, is the man at the top of a rampant medicaid fraud scheme known in street lingo as ``playing doctor.``

We documented the scheme at street level in May. Medicaid card holders, many of them drug abusers, led us to the medicaid mills where after virtually no examinations, unscrupulous doctors would write prescriptions for valuable drugs and medical supplies, which would then be obtained from look-the-other-way pharmacies and then sold for cash to specialized street dealers who often rerouted the same goods back to the same pharmacies.

But back to Kahn, we had seen him several times and video taped him once talking to employees of the various medicaid mills we had observed and we didn`t know who he was. Now we do. And we call him ``illusive`` because we have learned he operates behind a matrix of answering services and beeper numbers.

Our investigative sources from the Department of Social Services are getting a better and better view of his vast

empire, an empire consisting of medicaid bills, labs, and even billing services that rake in tens of millions of dollars a year. But Kahn slipped the net when they tried to set a trap for him at one of his Bronx clinics.

Mr. MATARASSO. We are looking for you. This is Mr. Matarasso. I am from medicaid. I have some papers here, where are you?

Mr. TAIBBI. And here is what happened when producer Anna Phillips and I did get to Kahn. We confronted him outside his house in Jersey City, confronted him after affirming, according to his driver`s license photograph and four separate sources, including two of his employees, that he was Mohammed Sohail Kahn.

Mr. KAHN. I am not Kahn.

Mr. TAIBBI. What?

Mr. KAHN. I am not Kahn. What are you talking about?

Mr. TAIBBI. You are not Kahn?

Ms. PHILLIPS. Who are you?

Mr. KAHN. Yeah, why should I identify myself? I am not Kahn.

Mr. TAIBBI. Your name is not Kahn?

Mr. KAHN. No.

Mr. TAIBBI. What is your name?

Mr. KAHN. Why should I tell you my name? Omar.

Mr. TAIBBI. Omar, you live with Mr. Kahn?

Mr. KAHN. I live in that damn building.

Mr. TAIBBI. Well, is Kahn--and this is what our investigation showed Mr. Kahn has been doing for years with your tax dollars. He rents office space, often shoddy store fronts like these, installs staff, receptionists, physician assistants, office managers, advertises for doctors and finds them, often doctors in financial or professional trouble. And with cooperating labs and his own billing services in place, sets the cash registers crackling.

One of his former physician assistants quotes him as instructing, we don't want repeat patients with real medical problems.

UNKNOWN SPEAKER. Old patients don't generate revenues.

RPTS GARLAND
DCMN MAGMER

Mr. TAIBBI. So just take a few old patients?

UNKNOWN SPEAKER. The new patients you can order blood work on them, and there is a big fee of $20 or something, but an old patient is about $8.

Mr. TAIBBI. One of his former physicians quotes him as instructing you don't even have to examine the patients. My physician says assistants can do that. Just sign the charts and prescriptions. Make sure the patients get everything they want.

This doctor became the first to speak on the record about Kahn when we visited her at her home.

UNKNOWN DOCTOR. I did question it more than once. And what I got as feedback as an answer was that while the patient--you have to treat the patient for what they ask. You cannot tell them, no. You cannot refuse a patient.

Mr. TAIBBI. And Kahn and his group, who never even appear on the provider roles, haul in medicaid millions nonetheless. It is the professionals he employs, the doctors and the physicians' assistants with high credentials to protect, who eventually get caught.

UNKNOWN SPEAKER. What he was saying, you can't get into trouble. If anyone, it is the physician.

UNKNOWN DOCTOR. Now, I do believe this is the wrong way

to do medicine, to depend on people to do, to bill--the billings should be controlled, the lab should be controlled, and it is very important.

Mr. TAIBBI. Do you admit that somebody using your name--

UNKNOWN DOCTOR. Yes.

Mr. TAIBBI. --and your provider number--

UNKNOWN DOCTOR. Yes.

Mr. TAIBBI. --robbed money from the State of New York and from the medicaid program?

UNKNOWN DOCTOR. Yes.

Mr. TAIBBI. Well, the doctors who spoke to us admitted they were hardly blameless, but we wondered where, anyhow, do Kahn and his cohorts find the doctors willing to risk everything, including a medical license, a professional standing to join this cynical game. I will have some of the answers tomorrow at 11:00.

ANCHOR PERSON. More of our exclusive service of doctors who write a prescription for danger, that risk their career in a game of medicaid fraud that steals millions of your tax dollars every year. Channel 2's Mike Taibbi first exposed this scam back in May, and tonight Mike reports on how those who run the game find doctors who are wiling to play along.

Mr. KAHN. I am not Kahn. What are you talking about?

Mr. TAIBBI. You are not Kahn.

Mohammed Sohail Kahn denied to us that he was who we knew him to be, the shadowy figure investigative sources say is at the top of one of the biggest medicaid fraud schemes in history. Those sources connect him to storefront medicaid mills, diagnostic offices and labs that are virtually money machines and, significantly, to the services that does all the bogus bills to medicaid for the doctors in Kahn's employ.

Now, while Kahn tried to lie to us in this face-to-face meeting, he did talk to me once by phone. ``I have nothing to do with medicaid,'' he told me. ``I just rent office space to doctors.''

Baloney, said this doctor, whose identity we agreed to withhold in exchange for a frank interview. He racked in tens of thousands of medicaid dollars after cutting a deal with Kahn to work in several of his medical mills.

UNKNOWN DOCTOR. He would have to pay the [inaudible],

which included receptionist, the certified [inaudible], aspirometer technician, and the certified PA--physician assistant.

Mr. TAIBBI. Physician assistant. Then Kahn would have that responsibility of paying those people?

UNKNOWN DOCTOR. Yes.

Mr. TAIBBI. In exchange for him taking that responsibility, what payments were you to make to him?

UNKNOWN DOCTOR. I have to pay, to pay him $6000 a month. He--the office has a billing system. He said that they have already somebody for the billing in the office.

Mr. TAIBBI. And what a system. When producer Anna Phillips went undercover to visit a number of medicaid mills in Manhattan, Brooklyn and the Bronx, she had drugs and pharmaceutical supplies prescribed for her and lab tests ordered in her name, all of it billed to medicaid, and she was in perfect health. In two instances, she was not even examined at all.

We know, because we observed from the inside, this is not the practice of medicine. It is the conduct of big business no matter what the managers say.

UNKNOWN SPEAKER. This is the first time, this business, and I am owner of this company. And I am very proud to say that we should be given a medal. We are doing a great social service, and I am proud of it. And if the others are

doing a mock or anything wrong, I do not know.

Mr. TAIBBI. But the manager should be worried and so should Kahn's doctors because the doctors are just as expendable as the drug buyers and the scammers at the bottom of the game. The doctors will get caught, usually within a few months, and they will be barred from any medicaid work, including hospital emergency room work, and, sometimes, but not always, they are prosecuted criminally.

Mr. DURKIN. We like to put the operators out of business. From the prosecutor's side of it, obviously, if there is more, they would like to put them in jail.

Mr. TAIBBI. That is why Dr. George Rubenstein told us he is worried about his connection to Kahn's organization. He told me he took the job because he had some money problems, but he asked me, am I in trouble here? I told him he ought to talk to medicaid before medicaid talks to him.

And yet, because doctors are people, too, and have financial burdens and lapses of conscience and trouble finding work, Kahn's empire has no shortage of MD shingles to hang over the doors of his medicaid mills.

And where do those doctors live, the doctors who make all that money, your money, off medicaid? Well, one of them lives right here in the tidy little enclave known as Harbor Hills on Long Island's north shore, also known as the Long Island Gold Coast. His name is Dr. Gilbert Lee Ross, and

for showing up at this Bronx medicaid mill two days a week for only nine weeks, for doing nothing more than signing charts and prescriptions for patients he never examined, he made $85,156.75 of your money.

In a prior telephone conversation with me, he admitted it wasn't right, but he was afraid of what might happen to him and so quit the game. But when Anna and I confronted him on the way to Long Island's Jewish Hospital, he was less forthcoming.

Dr. ROSS. I was not at all sure what was going on, but I didn't want to take any chances.

Mr. TAIBBI. Well, you had questions. You said you severed the association with Kahn, correct?

Mr. TAIBBI. Well, I left the clinic, sure.

Mr. TAIBBI. All right. I mean, did it occur to you this was not quite kosher, so to speak, that you were involved in a practice that wasn't the delivery of medicine? You were not seeing patients, you were just signing charts.

Dr. ROSS. I was supervising the charts, yes.

Mr. TAIBBI. You told me--this is what you said. Someone was going to make the money. Why not me?

Dr. ROSS. That is not true.

Mr. TAIBBI. Doctor, I have notes saying you said that, Doctor.

The three doctors featured in this report all had admitted

to us in one way or another that they knew what they had gotten into, but there are doctors who walk into schemes like Kahns unaware that, basically, they are there to be exploited.

In tomorrow's concluding report, you will meet one of those doctors and learn what the state can and cannot do to rout out the Mohammed Kahns infecting the Medicaid program and consuming all of your tax dollars.

ANCHOR PERSON. Okay, Mike.

583 ANCHOR PERSON. Doctors putting their careers on the line
584 to play a dangerous game of medicaid fraud. Channel 2's
585 Mike Taibbi has been reporting exclusively the scam and the
586 kingpin behind it. Tonight, whether those infecting the
587 medicaid system can be stopped.
588 UNKNOWN SPEAKER. Okay, let's tell me what is going on.
589 Mr. TAIBBI. Doctor, Denise McNair has a busy family
590 practice in Williamsburg, Brooklyn, a real practice where
591 real medical care is delivered to real patients who happen
592 to be on medicaid. Every patient of hers with whom we spoke
593 praised her and thanked her.
594 UNKNOWN SPEAKER. She is a very good doctor. She takes
595 care of all of your needs, all your problems. She is a
596 really good doctor.
597 Mr. TAIBBI. But for a short time, just a few weeks, Dr.
598 McNair also worked in one of the Harlem medicaid mills
599 allegedly run by Mohammed Sohail Kahn, who was described by
600 our sources in previous reports as sitting atop one of the
601 biggest medicaid fraud schemes in New York history.
602 Dr. McNair thought she would do in Harlem what she had
603 been doing in Williamsburg. Instead, under her provider
604 number, the Kahn organization billed medicaid for some bogus
605 or questionable lab tests, procedures and prescriptions,
606 that Dr. McNair found herself being warned of
607 disqualification from medicaid.

And, in truth, it looks at this point that Dr. McNair, like other doctors and pharmacists, was victimized by medicaid fraud entrepreneurs who see health care professionals as being just as expendable and replaceable as the drug abusers and scammers whose ticket to the game is the medicaid card.

The so-called entrepreneurs do not care if Dr. Gilbert Lee Ross is prosecuted for his nine week, $85,000 medicaid feeding frenzy. He has admitted to us all he did for those nine weeks was to sign charts and prescriptions a couple days a week, and that he then quit the medicaid mill because he didn't want to take any chances.

And the entrepreneurs certainly don't care if the consequences of all those health care providers getting into trouble is that no doctors or pharmacists want to work any longer in the underserved communities medicaid was designed to help.

Do you see a way or can you think of a way you would ever get involved in a medicaid practice again?

HARLEM DOCTOR. Don't want to hear about it.

Mr. TAIBBI. Don't want to hear about it?

HARLEM DOCTOR. No.

Mr. TAIBBI. You are all done with it?

HARLEM DOCTOR. Yes.

BROOKLYN DOCTOR. All of a sudden they are not sending any

money. I don't know what is the reason, but if they don't send money, all these pharmacists would be out of business as fast as maybe within a week or two.

Mr. TAIBBI. It doesn't help necessarily for them really to have less physicians and less care. I understand the state's position, but I think that you also have to look at the fact that you are going to wipe out a significant number of practitioners in the low income areas. They are just going to not practice or not see medicaid patients. That has happened.

Mr. GAIMO. Do not put the doctor who caters to the poor person out because when you put the doctor out you are putting the patient right out.

Mr. TAIBBI. As Department of Social Services investigators have refined their understanding of how the entrepreneurs operate, they have started going after them. Kahn is among the first targets. Among the contemplated charges against him, filing false and excessive claims for medical services and supplies and failing to furnish needed medical care.

Up to this point, rooting out medicaid fraud has meant nailing some doctors and pharmacists and disqualifying ineligible cardholders and developing whistle-blowers like this man, who is, essentially, a bag man delivering payoffs from one huge lab to the doctors who channeled unnecessary

test requests to that lab.

BAG MAN. They were all snow jobs.

Mr. TAIBBI. So the lab would list these people as employees when, in fact, they weren`t employees?

BAG MAN. They were doctors` relatives, friends, brothers, sisters, whatever.

Mr. TAIBBI. How big were these checks? You peeked at them a couple of times.

BAG MAN. Well, one that I could recall, really, was for about almost a thousand.

Mr. TAIBBI. Those are important potential cases, big money cases, but with fraud estimated to consume anywhere from 5 to 25 percent of the state`s $14 million annual medicaid budget, going after the entrepreneurs like Mohammed Sohail Kahn is now the state`s number one priority.

Mr. PERALES. It is something that we will be doing over the next few months for the first time, and I am optimistic that the courts will support our ability to find entrepreneurs. It is one more weapon to get these entrepreneurs out of the system.

Mr. TAIBBI. All right. Where does the case now stand against Mohammed Sohail Kahn? As we said, the state was prepared to move against him in a civil action, but before investigators could serve him with papers, the Federal government expressed an interest in the case. And with state and Federal investigators now on the case, we have learned they have come up with even more on Kahn and on another alleged operator who may be running an even bigger ring.

We will track the investigations and keep you posted.

Mike Taibbi, Channel 2 News.

Mr. DINGELL. The Chair notes that is the conclusion of the presentation. Chair would now recognize the panel in any order they would choose.

We can start with you, Mr. Anderson, Mr. Koppelnick, or you, Mr. Kuriansky. We leave the choice to you as to order in which you would testify.

Mr. ANDERSON. Mr. Kuriansky has a prepared statement, so we will start with him first.

Mr. DINGELL. Very good.

Mr. Kuriansky, we will recognize you first.

Mr. KURIANSKY. Mr. Chairman——

Mr. DINGELL. I tell you what, gentlemen, the Chair has been advised by counsel that we would be well served to proceed to ask some questions of Mr. Koppelnick. So Mr. Koppelnick, if that is not offensive to you, the Chair will proceed in that fashion.

Mr. Koppelnick, the Chair inquires, does the film we saw accurately depict the way the Medicaid system is abused in Baltimore?

TESTIMONY OF JAN KOPPELNICK, BALTIMORE, MD., ACCOMPANIED BY DANIEL R. ANDERSON, DEPUTY CHIEF, MEDICAID FRAUD CONTROL UNIT, OFFICE OF THE ATTORNEY GENERAL, STATE OF MARYLAND; AND EDWARD J. KURIANSKY, SPECIAL PROSECUTOR FOR MEDICAID FRAUD CONTROL, STATE OF NEW YORK

Mr. KOPPELNICK. Yes, sir. I mean——

Mr. DINGELL. Yes?

Mr. KOPPELNICK. Yes, even—you are just hitting the top of the iceberg. They are using noncontrolled substances in Baltimore, more or less. They use controlled substances and they go for like, for a dollar and a quarter for a Medicaid prescription, for a 100 Xanax, you are talking about $250 back, and you can probably sell them in 15 minutes.

Mr. DINGELL. So we can say that it is representative of the general situation, but in Baltimore there is a problem in addition to that with the way controlled substances are handled, is that correct?

Mr. KOPPELNICK. Very much so.

Mr. DINGELL. What would the situation with regard to controlled substances be? How would you tell us that is going on?

Mr. KOPPELNICK. The last situation?

Mr. DINGELL. Yes, sir, if you please.

Mr. KOPPELNICK. How I—well, I spent a lot of time incarcerated for various drug violations, and during that time I digested medical books and pharmacology books, and I can pin a doctor down with what I need—do you want a specific example, like for the drug, Dilaudid?

I would prick my finger and I would say I had kidney stones, and he would give me a urine test, and I would go in the bathroom and the blood would drop in the urine. He would see the blood, send me out, and give me initially 21 Dilaudid tablets.

I would go to the store, cost me a dollar and a quarter, they go for $35 each in Baltimore apiece, four milligram Dilaudid tablets. And since usually we have a back up, they usually give you a drug,

Phenergan, to potentiate the affect of the Dilaudid. And usually, since I would be suffering from anxiety, Xanax along with it.

And then I would go to the next guy. I would probably do this six times a day, I mean before this Medicaid fraud unit. It was a lot easier before about 3 years ago.

The gentleman to my left and the lady and gentleman in back of me have made it a little more difficult in Baltimore.

Mr. DINGELL. Thank you.

Now, what would be the situation for Medicaid recipients who wish to defraud the system? Do they have any difficulty in finding doctors or pharmacists who are willing to work with them to defraud Medicaid?

Mr. KOPPELNICK. Personally, I don't—I mean, you just go until you, I mean there is some of them. I mean, in Maryland, a physician's office visit is $35 today. In the future, it is going to go up to $42. You walk in the door, that is $42. He writes you the prescription. Any pharmacy will crack that prescription.

Can I use street terms; crack the prescription? I mean, as far as, you know, I mean I am talking about reputable firms, like Rite Aid and chains of Giant Food. There is no problem cracking the prescriptions.

And if you look at me, I don't look—do I look like the run of the mill dope addict? I have no scars usually, you know. If I get a doctor—once I get in—I am a little nervous now, of course. When I am going in with a doctor, I am probably a little sedated and I wouldn't be as nervous as I am now and I am flowing more freely. I am like I used the Dilaudid example, or I can use a drop of joy in my eye and it is called conjunctivitis. I can say I am allergic to several different other drugs and I have used this one drug before and it works. And I can usually corner a physician into giving me what I want by saying I am allergic to this, but that doesn't work, and I am talking this, and there is so many ways to run your blood pressure up and run your temperature up and speed your pulse, and it is very easy, Mr. Chairman, I am sorry to say. I mean, even legitimate doctors, but there is more than enough illegitimate doctors to go around.

Mr. DINGELL. Thank you, Mr. Koppelnick.

Now, how would you find out? If you intended to participate in some kind of a Medicaid fraud, how would you identify the doctor or the pharmacist to whom you would go? How would you know which one that you would do business with under those conditions?

Mr. KOPPELNICK. Well, it is my peer group, sir. I am on a methadone program; OK? Are you familiar with methadone?

Mr. DINGELL. Yes. How would you identify where you would go to get a false prescription filled or to get a prescription filled——

Mr. KOPPELNICK. These aren't false prescriptions. Schedule II prescriptions in Maryland have to be verified. They have to call the doctor. I just wrote one here, when I get a prescription, I just wrote one, but it is a Schedule IV. A Schedule II prescription has to be verified in Maryland—how do I find doctors—I cruise the area. The area I live in, in Pikesville, there is a lot of them. And I usually go out of the area, where there is the corner physician, family practitioners where, you know, it is a hit and miss thing. I mean, on an average, I can make one out of three.

Mr. DINGELL. So basically, you are telling me that the people who would engage in this kind of practice, either in the pharmaceutical business or in the medical profession, would be generally known in the community—is that it, and you would go to these people?

Mr. KOPPELNICK. It is like a line. Like you just saw there. See, the bad thing is—all right, if I get a doctor and I turn Mr. Anderson on to the doctor, what happens is he gives me half his first script for everything he gets. Then, he has the doctor after that. Then, in turn, it is the donor theory. He goes and it goes down. Do you follow me? And that is how it works.

Now, if I get a really good one, that is going to write for Schedule II's, like Dilaudid or Levo-Dromoran or Fentanyl, then I probably will keep him to myself. But as far as Xanax, Phenergan, what they are talking about, what you just saw on the television, the doctor doesn't even need to see you. They are call-ins. I can call in a Phenergan prescription.

You know, this is Dr. Koppelnick; I have a patient coming in, and—do you want me to go through the whole thing, what I would say to the pharmacists?

Mr. DINGELL. I am sorry?

Mr. KOPPELNICK. Do you want me to go through the whole thing?

Mr. DINGELL. Mr. Upton says he would like that and I think I would, too. Please.

Mr. KOPPELNICK. The phone will ring, the cashier will answer, and pharmacist, please; yes, this is Dr. Koppelnick; I have a patient coming in for a prescription. Pharmacist will answer, yes, doctor. The prescription will be Xanax, 1 milligram, 60 tablets; dispense 1 tablet t.i.d. and you put two refills on that. My DEA number is AJ1234567 because there are eight DEA numbers. Of course, I would have to find a DEA number and most pharmacists won't check the DEA number on first Schedule IV—when you are going for a Schedule IV drug. That is it. It is that simple. And if you call for nonschedule substances, like Phenergan, which is a potentiator, or a Schedule V, for like cough medicine, I mean it is a joke. And now—and you want Medicaid, of course.

The Medicaid is, the doctors love Medicaid. I mean, you walk in the office for 5 minutes. You tell them, look at me, I am nervous now; you can see I am nervous. I do this, I mean I am really nervous now, but I do this as an act, and he will give me a prescription for Xanax.

I will run my blood pressure up, because I do have hypertension. I will get Clonidine. I will get a 100 Clonidine, a 100 Xanax, a 100 Phenergan, and I will get 30 Placidyls for sleeping. And that total is probably, at the pharmacy is, is close to $200. Because there is no generic, Upjohn still owns the patent for Xanax; Abbott still owns the patent for Placidyl.

The 17 year—you, gentlemen, ladies and gentlemen, gave the pharmaceutical companies 17 years for patents, so there is no generic equivalents, and most people would prefer the real drug than the generic because they can't identify it. I mean, I can identify it because you can ask me a drug, what the patient is on, in the Physicians Desk Reference, and I can tell you, and I can tell you the

cases and the, as the doctor can tell you, we have already talked, I know what to say.

And I am not unique, believe me. There is plenty of people around that can do this.

Mr. DINGELL. Thank you.

Now, would you say that the numbers of doctors and pharmacists who are going along with or perpetrating this kind of fraud are remaining stable—is it growing, or is it decreasing?

Mr. KOPPELNICK. It is decreasing in Baltimore because you have the Medicaid fraud unit. It is decreasing—they are backing off big time.

Mr. DINGELL. Thank you.

Mr. KOPPELNICK. Because there has been a lot of photoplay in the Baltimore Sun. In the last 18 months it is, I would say it has been cut in half. But it is still available.

Mr. DINGELL. Thank you.

Now, you told the staff that the types of doctors and pharmacists who are abusing the system are not just shady, fly-by-night operators, but rather mainstream ones who might devote a single day or a portion of their practice or business to Medicaid patients, is that a correct statement?

Mr. KOPPELNICK. Yes, sir.

Mr. DINGELL. Now, Mr. Koppelnick, you described one doctor who saw exclusively Medicaid patients and you indicated that he saw specifically 20 of them each hour, between 130 to 150 each day. Is that the way doctors do business who engage in this type of fraud?

Mr. KOPPELNICK. I think there was a miss—we were talking about a psychiatrist that was supposed to be seeing patients for 50-minute intervals and billing as such. He was seeing 35 to 50 in a 24-hour period and—I mean, we can all count. You can't see 50 people in 24 hours at 50-minute intervals and 10 minutes in between.

In other words, you go in, he gives you the prescription, you—he writes it down, it is this. It is so bad sometimes they have stamps because they have to do it so fast. They don't have, they don't want to write their name. They have to stamp them that quick and they are in and out.

In particular, there was one in prosecution now. We don't want to mention his name.

Several are already going down the tubes, if you want. I mean, one recently with the sex for drugs was a joke. I mean, it looked like a clinic. I mean, it was, he had six rooms and he would be going from room to room. This isn't a psychiatrist; this was an internist and a—with old people.

Mr. ANDERSON. Geriatric.

Mr. KOPPELNICK. Geriatric medicine. He would be going from room to room, and he was a reputable doctor with the elderly people. But in the morning from 9 to 12, it was us, meaning the dope addicts, whatever you want to call me. And it is room to room. I mean as fast as he could write, as fast as he could get out of there.

I know it is fascinating but, believe me, it is true.

Mr. DINGELL. Thank you.

Now, you told the staff that there are Medicaid recipients who know how to con a responsible physician or pharmacist into prescribing drugs that are abused; is that right?

Mr. KOPPELNICK. That is correct.

Mr. DINGELL. Is that a fact that there are——

Mr. KOPPELNICK. Is correct. I have had my attorney tell me, how do you do this. I send you to real doctors. I had a building fall on me. I know it sounds crazy, and I don't want to get into that. I was walking down the street and a building fell on me. It is a long story, but, I mean—so, of course, I go to a reputable doctor and, of course, he, the bill was charged to my attorney. He says how are you getting these doctors, these real doctors, to write for you? Because I can, I mean that is what I read, medical books, medical journals and pharmacopoeias and PDR's and pharmacists red books. I mean, that is the only thing that fascinates me.

Mr. DINGELL. What should we in the Congress do about this kind of Medicaid fraud?

Mr. KOPPELNICK. You are letting the doctors police themselves. Dr. Roewingle, I mean you are letting the fox guard the chicken coop. You are letting the doctors police themselves. I mean, in Maryland we have Medi-Chai; is that——

Mr. ANDERSON. A licensing body.

Mr. KOPPELNICK. It is a licensing body. I mean, it is a joke, Mr. Chairman. It is like when I was in prison. They made me a pharmacy tech. I ate the whole pharmacy. Of course, the Secretary of Public Safety and the Commissioner of Corrections were fired afterwards, but the pharmacy was gone. I ate the whole pharmacy.

Mr. DINGELL. Well, Mr. Koppelnick, thank you for your very helpful testimony.

Mr. DINGELL. Mr. Kuriansky, we recognize you now.

TESTIMONY OF EDWARD J. KURIANSKY

Mr. KURIANSKY. Thank you, Mr. Chairman.

I am very pleased to appear before you today to discuss the subject of Medicaid fraud and abuse which is obviously a subject which requires some discussion.

It is a special privilege to appear before this committee which some 14 years ago initiated the landmark Federal legislation that has established and funded the Medicaid fraud control unit program.

Since that time, nearly 40 States have initiated fraud control units and well over 5,000 arrests of corrupt medical providers and venders ensured. Prosecutions there, I think it is fair to say, would surely not have been brought without this vital piece of legislation.

In a very real sense, the Medicaid fraud control unit program now feels the pivotal role in the surveillance and enforcement of this Nation's health care industry, much as the IRS and SEC have long served as an integrity check on our taxing and securities systems.

Medicaid, as you certainly know, is the primary health care program for 28 million Americans of America's poorest and old citizens. On a national level, Medicaid expenditures totaled more than $60 billion last year and will cost well over $70 billion this year.

While most of these taxpayer dollars go directly toward providing needed medical care for the intended beneficiaries, a tremendous amount is lost to fraud and abuse year after year as the program continues to offer the kind of sizeable cash awards that attract predatory and extremely cunning providers.

Regrettably, the Medicaid program at age 25 must be seen as a program that has all to often failed, certainly not in its ideals but in its execution, a program of too little access, too little quality and far, far too much abuse.

For over 10 years now, numerous congressional, governmental and private insurance groups very consistently estimated the fraud and abuse in the Medicaid program and, indeed, in our health care system, in general, at somewhere between 5 and 25 percent. And while there may be no way to put a precise figure on it, we are certainly talking about many hundreds of millions, and most likely billions, of dollars.

Medicaid fraud is certainly no stranger to New Yorkers, who, as far back as 1974, were worked by a nursing home scandal of immense proportions. Patient abuse, theft and official misconduct and corruptions were commonplace.

In response, New York became the first State in the Nation to appoint an independent prosecutor to investigate health care fraud and abuse, and the organization of this office, namely, a coordinated team of lawyers, investigators and auditors operating—and this is important—separate and apart from the single State agency that administers the Medicaid program, ultimately provided the Federal statutory model for the Medicaid fraud control unit program.

Special Prosecutors Office is now the largest statewide operation in the country dedicated exclusively to the investigation and prosecution of health care crime.

Since the inception of the office in January 1975, our investigations have resulted in the arrest of over 1,700 defendants, with an overall conviction rate of 92 percent. In addition, the office has instituted the recovery of more than $131 million in overpayments, fines, and restitution. As the investigative agency primarily responsible for monitoring the $14 billion annually spent on Medicaid in New York State, approximately 20 percent of the Nation's total, we have been witness to some of the largest and most sophisticated frauds ever committed against the program.

During the past decade, in particular, we have literally seen a feeding frenzy on the Medicaid program, a period of unprecedented white-collar wilding in which wave after wave of multimillion dollar fraud has swept through nursing homes and hospitals to clinics and pharmacists, podiatry and durable medical equipment, radiology and labs, and more recently home health care. Each surge has brought its own special brand of profiteer in search of the next great loophole in the Medicaid system.

Perhaps the most notorious case of all was that of Sheldon Weinberg and his two sons, Jay and Ronald, who systematically looted more than $16 million of the $32 million their Brooklyn health care center received from Medicaid for supposedly treating the city's poor from 1980 to 1987.

The Weinberg scandal included falsely billing Medicaid for close to 400 phantom patient visits, first by paying a clinic dentist on a

percentage basis to do nothing but fabricate and file fraudulent Medicaid invoices, and then, at its height, by actually programming a computer to generate bogus claims and back up medical charts for as many as 12,000 fictitious patient visits a month.

In November, 1988, after a 5-week jury trial, the three Weinbergs were all convicted. On January 10, 1989, Jay Weinberg was sentenced to 8⅓ to 25 years in jail, and his brother, Ronald, to 5 to 15 years. Their father, however, had to be sentenced in absentia because he had run away the night before his sentence.

Fortunately, Sheldon Weinberg's flight from justice proved to be surprisingly short-lived. As a direct result of television viewers' tips, within hours of a specially broadcast reenactment of his crime on NBC-TV's Unsolved Mysteries, he was located and apprehended before dawn in Scottsdale, Ariz., notwithstanding the fact that he had, in the interim, grown a beard, entered into a sham of a marriage and assumed a new identity.

It was somehow fitting that ordinary citizens whose millions of stolen tax dollars directly financed Weinberg's obscenely lavish life-style, that included an $18,000 a month apartment in Manhattan's Trump Tower, a $5 million lakefront mansion in Boca Raton, Fla., yachts and a fleet of custom cars should be the instrument of his ultimate downfall.

Mr. Weinberg is now serving 7 to 21 years in the Attica State correctional facility.

While the Weinbergs may have committed the single largest Medicaid fraud in American history, they certainly had no corner on the criminal market. Throughout the 1980's, we found nursing home operators and hospital administrators taking kickbacks from facility vendors as well as charging off personal luxury items on Medicaid cost reports. We found nursing homes discriminating against Medicaid recipients by demanding unlawful payments in return for admission or simply dumping them in favor of higher-paying private patients.

Sadly, we continued to find isolated, though not infrequent, instances of nurses, aides, and orderlies raping, sodomizing, beating, kicking and force-feeding the helpless and often incompetent patients in their charge.

We also found pharmacies—pharmacists—shorting and fattening prescriptions, substituting generic drugs for brand names, buying up forged script and resold drugs and creating telephone refill orders out of thin air.

Then, of course, there were the physicians.

We found doctors charging for nose jobs, abortions, allergy, hearing, heart, lung and range of motion tests they never performed; doctors billing while they were away on vacation or out sick, and even double billing for autopsies.

We found podiatrists charging for foot surgery when they were actually giving pedicures and trimming toenails; pediatricians billing as psychiatrists and psychiatrists time-beating their patients.

And we found all sorts of doctors splitting fees in return for rent, demanding under-the-table cash payments from Medicaid patients, and taking kickbacks—millions and millions in kickbacks—in exchange for ordering everything from drugs and sonograms to blood tests, orthopedic shoes and durable medical equipment.

Finally, we found complete phantoms—nonexistent doctors, dentists, shoe stores, clinics—that had been fraudulently enrolled in and were banging away at the Medicaid program for hundreds of thousands of dollars.

Even more striking than any of these individual scams, however, has been the changing face of the Medicaid cheat over the past 10 years. By the early to mid-1980's, indeed paralleling the rise of Wall Street's famous insider traders, we had begun to see in New York the emergence of a different kind of Medicaid entrepreneur—the young professional, seemingly without ethical standards and determined to bankroll his medical education and early career at taxpayer expense. His schemes were more ambitious, more complex and more costly to the public than those of his predecessors.

The archetype of this yuppie thief was Dr. Jeffrey Simon, a podiatrist and owner of five orthotic labs in suburban Westchester and Rockland County, who masterminded the biggest and most complicated podiatry fraud yet perpetuated on this Nation's Medicaid system.

During his 4-year scheme he billed Medicare for nearly $2 million worth of expensive, customer-made foot appliances—inlays, arch supports, plates and molds—while actually providing his recipients with cheap stock goods or nothing at all.

He recruited young graduates, fresh out of podiatry school, to help him, paid kickback to dozens of New York City area podiatrists for steering business to his labs, filed tens of thousands of false claims for useless orthotics, fine-tuned his scam on a yearly basis to evade government scrutiny, and finally, even created a mock laboratory in his office basement, complete with tools, leather dust and foot molds taken of his own employees' feet, in a last-ditch effort to dupe State inspectors.

On August 11, 1989, Simon was sentenced to 3 years in prison.

I thought you might be interested. I brought with me today to show you what Dr. Simon was giving to his patients. These foam rubber cookies, they are called. They cost him and his employees about $2 apiece to make. He was billing Medicaid for $220 plastisol molded inlays, and when the Medicaid program finally caught on and said, you can't bill for those $220 inlays any more without prior approval, he dropped down to a $100 item, and when they said, no more $100 items, he dropped down to a $46 item, all the while producing these.

In addition, we often found retail shoestores working in tandem with corrupt podiatrists. The doctors in return for kickbacks from the stores would routinely prescribe expensive and unnecessary orthopedic footwear for literally thousands of Medicaid recipients, and the stores would just as routinely issue them sneakers and fashion shoes.

So flagrant was the practice that one podiatrist even went so far as to hand out leaflets in the neighborhood reminding parents to get back-to-school shoes for their children.

In over 50 shops of these stores during one particular sweep, our undercover agents were never once offered orthopedic shoes for the prescriptions they had in hand but rather were told to select from a variety of sneakers, high heels, boots, loafers and moccasins on display in the stores. These $5 to $10 wholesale high heel shoes

were among those we received and for which the shoestores were regularly billing Medicaid $50 to $75 for orthopedic prescription footwear. We have cartons, bagfuls of these that our agents walked out of these shoestores with.

So far, our investigation of podiatrists, orthotic labs and orthopedic shoe vendors has resulted in criminal charges against 186 defendants for stealing nearly $29 million from the Medicaid program. They have almost, every one of them, been convicted.

Equally important has been the dramatic decline in annual Medicaid expenditures in the aftermath of this enforcement activity. Indeed, prescription footwear payments dropped from nearly $30 million to $3 million a year, and podiatric service claims fell from $35 million to $13.4 million a year, a saving to New York's Medicaid program of perhaps as much as $240 million in the past 5 years.

From the mid-1980's up until the present time an even more fundamental change has taken place in the operation of inner-city Medicaid mills that has led to a frightful expansion of illegal activity. I refer specifically to the rise of a new breed of Medicaid profiteers who thrive on the multiple, often hidden ownership of clinics that constitute nothing more than barely furnished, utterly inadequate medical facilities and that are often incestuously associated with pharmacies suited to little else than rapidly dispensing massive quantities of drugs and other high-cost Medicaid items.

Moreover, these providers are increasingly of foreign extraction, with the ability at the first sign of trouble to return to their homeland enriched with thousands, even millions of taxpayer dollars. Indeed, many of our defendants and potential targets have been traced in recent years to Pakistan, India, Malaysia, Israel, Ghana, Nigeria and Haiti.

As a rule, too, these entrepreneurs do not themselves come in contact with the daily operation of the mills and often use anonymous, centralized computer-directed billing systems. They hire physicians' assistants and unlicensed staff to run their assembly-line operations. They move them around rapidly and change ownership structures frequently.

Furthermore, violent crimes, such as arson and the possession of deadly weapons, are now often part and parcel of the traditional white collar larceny schemes, and whereas only a few years ago program thefts generally ranged in the area of $50,000 to $100,000, Medicaid frauds today now frequently total a million dollars and more.

These new businessmen, unlike their nursing home owner forebears, are in business for the sole and exclusive purpose of exploiting the Medicaid program and have no interest whatsoever in delivering real medical care to real Medicaid patients.

Such was certainly the case of Dr. Surinder Singh Panshi, who spearheaded perhaps the most nefarious fraud ever perpetuated on this country's health care system, namely the illegal trafficking in human blood for millions of dollars in profit.

The preliminary findings in this case shocked even our most seasoned investigators, who in early 1988 were advised by nurses at a local methadone clinic that their Medicaid patients would no longer allow blood to be drawn for testing purposes because they

had discovered several Bronx locations where they could sell their blood for $10 to $20 a half pint.

At the same time, physicians in the emergency room in Manhattan's Columbia Presbyterian Hospital reported treating several previously healthy young patients who required hospitalization and massive transfusions for life-threatening anemia and who acknowledged having sold half the blood in their bodies at these same Bronx collection points.

Shortly thereafter, we executed search warrants on Bronx tenement apartments and seized over 1,100 vials of unidentified blood, needles, rubber gloves and a sawed-off shotgun. Subsequent testing of these blood samples revealed the presence of both the HIV and Hepatitis B virus.

The investigative trail eventually led to a blood trafficking ring run by Pakistani and Malaysian immigrants and secretly controlled by Surinder Singh Panshi—a defrocked doctor and a previously convicted Medicaid provider. He worked together with his 68-year-old father, Gurdial Sing Panshi.

Their elaborate empire extended from the dirty and dangerous blood-drawing depots they established in the Bronx to "shell" management companies they set up in Brooklyn to do nothing but buy, collect and package the illicit blood and, finally, to full-scale clinical testing laboratories in Queens and Long Island that they controlled and billed through.

They brazenly urged any accomplices who attracted law enforcement heat to flee the United States for their native Pakistan, as five of them actually did. Their scheme was so detailed that the size of kickbacks paid to the assorted salesmen and blood collectors fluctuated daily according to street market conditions.

Panshi's salesmen regularly picked up 150 to 200 vials a day per depot and paid their collectors $25 a vial. The labs then ran the blood through testing machines to create the necessary fraudulent paper trail and billed Medicaid for batteries of high-priced and utterly useless tests.

In August 1988, Dr. Panshi, his father and their three clinical laboratories were charged with stealing more than $3.6 million, the largest Medicaid lab fraud in U.S. history.

Time magazine said appropriately of the Panshi scheme: The crime was perfect only in its ghoulish symbolism. The perpetrators drew blood from poor people, paying them as little as 50 cents a vial, then falsely claimed the samples came from Medicaid patients and billed the government for millions of dollars' worth of bogus lab tests.

Less than a year after his arrest, Dr. Panshi pleaded guilty to the entire 127-count felony indictment against him and is now serving a 5 to 10-year prison term. In December 1989, the New York City weekly, The Village Voice, bestowed on him the dubious title of Criminal of the Decade.

On a positive note, however, Panshi's jailing, together with a series of tough administrative actions and two subsequent Federal-State lab sting operations at other labs have had a demonstrable deterrent impact. Medicaid expenditures for clinical lab services in New York have now plummeted from a high of $170 million 3 years ago to a projected $55 million this year.

Usually, however, for every loophole in the system we close, voracious providers seem to find another. Only 2 weeks ago, we arrested a Queens radiologist for stealing over $1 million from the Medicaid program by repeatedly billing for thousands of medically unnecessary, duplicative, forged and largely unreadable sonogram tests.

Earlier this summer, a self-employed Queens cab driver, Abdul Majeed, was sentenced to a year in jail after he admitted fraudulently billing Medicaid $150,000 for bogus ultrasound tests. Majeed had carried out his scheme by taxiing junkies from Harlem to his Queens apartment, paying them $10 each to lie down and pose for useless sonograms, and then forging doctors' and recipients' names on test request forms.

These cases appear to be only the tip of the iceberg in what may well turn out to have been a $75 million ripoff in the ultrasound industry as the 1980's came to a close.

As for the decade of the 1990's, it is already presenting serious new challenges to the integrity of the Medicaid program—not the least of which may be the gathering storm of home health care. It is already the fastest growing part of our Medicaid-funded health care system, and in New York alone has ballooned from a $400 million to a $2 billion-a-year outlay in less than 5 years.

We in New York have only just begun to scratch the surface of this industry's potential criminal activity but have already uncovered three major Medicaid frauds totaling more than $7.5 million. And not only are the defendants in these cases charged with grossly inflating the number of hours their companies worked but, far more importantly, with recklessly sending untrained, unqualified and unlicensed aides into the private homes of thousands of critically-ill and care-dependent patients. This is clearly an area that will bear very serious watching in the future.

But perhaps our most pressing concern in New York today is the recent phenomenon known as playing doctor. As you have seen on the tape today, it involves a vast network of Medicaid physicians, pharmacists, and recipients engaged in the blatant dealing of drugs and script for cash on the black market. And, unlike many of the earlier frauds, this one is as much driven by recipients and their desire for drugs as it is by corrupt providers.

As we speak at this moment, this scam is plaguing ghetto communities throughout New York City and probably costing taxpayers upwards of $150 million a year. I will defer a detailed description of it because I think you saw it in all its glory on the TV screen, and we are indebted to Mike Tiidi and Anna Phillips of WCBS-TV in New York for that terrific piece of investigative journalism.

I think what the gentleman next to me was saying, though, bears some repetition, and that is that the recipients who play these doctors, they know exactly how to play them. They know the exact buzzwords they need and the symptoms they need to describe.

They say that I have got ulcers if they want Zantac, that I have got allergies if they want Seldane, that I have got depression if they want Prozac, backache if they want Feldene. They are very sophisticated, and it is also extremely easy, at least in the inner city in New York, to know which doctors are playing the scam,

which patients you can talk to, which noncontrol men you can go to.

We are not only seeing the drugs bought up by these noncontrol men going back into the pharmacies, but we are beginning to see some of it going out of State and out of country to Puerto Rico, Columbia and the Dominican Republic. The beauty of this scheme for each of the players—the physician, the pharmacist, the recipient, the nonman—is that each one gets his own very generous slice of the Medicaid pie and with, as the laws currently exist, relatively little risk.

In closing, I must emphasize that this ongoing spectacle in and about ghetto clinics and pharmacies of long lines of drug abusers who seek not to obtain legitimate medical care but rather to sell their Medicaid cards and medications for cash cannot be adequately addressed by criminal investigation and prosecution alone. A genuine solution to this Medicaid fraud drug diversion epidemic, as well as many of the other abuses I have touched on today, will require a vigorous and broad-based response by all State and Federal legislative, administrative and regulatory bodies that oversee the Medicaid program.

As long as Medicaid remains essentially a fee-for-service program that grants patients freedom of medical choice and depends largely on provider honesty, State prosecutors and administrators nationwide will require a vast array of surveillance and enforcement tools.

For example, since it is the physician's power to write script and demand kickbacks from other providers that fuel some of the more flagrant abuses, we in the States need the same tough felony kickback statutes and realistic immunity and accomplice corroboration rules that already exist under Federal law.

To deal, in particular, with the ongoing hemorrhaging caused by the playing doctor scam, we need new State and Federal laws specifically prohibiting the sale, the resale, repurchase and redistribution of Medicaid drugs and supplies.

We need a mandatory photo ID program to help curb the illicit sale, purchase, rental and theft of Medicaid cards, especially rampant in large urban areas.

We need what are called utilization thresholds to restrict at least somewhat the number of doctor visits, prescriptions, lab tests, and DME supplies a recipient can receive without prior State authorization. It is simply intolerable that Medicaid could, as has happened in New York, be billed in the name of a single Medicaid recipient in a single year for $170,000 worth of AIDS medication or $50,000 worth of blood tests.

We need to impose a strict prior approval system on all big ticket DME items, such as prescription footwear, orthotic and prosthetic devices, wheelchairs, seat lifts and breathing equipment.

Very important, we need to require performance bonds or other financial security from high-volume providers so as to discourage hit-and-run assaults on the program by those who once caught might be tempted to abscond the jurisdiction or secrete their assets abroad.

We need to institute, as in Medicare, an aggressive EOMB, or confirmation of benefits process, because, more often than not,

Medicaid recipients are themselves utterly unaware of the fraudulent and inflated claims doctors and pharmacists are making in their names.

Until Medicaid moves more broadly toward an HMO or other managed-care treatment modality, we need to consider eliminating or severely limiting certain optional services, certain fraud-prone services such as podiatry and audiology.

We need to tighten up provider enrollment procedures so that we know at least as much about a prospective Medicaid biller as we do about a typical applicant for a driver's license.

Finally, we need to streamline and toughen up the physician disciplinary process so that assembly-line, pill-pushing practitioners are treated as the serious menace they are and that those convicted of felony frauds are stripped—like lawyers and nursing home administrators are—of their professional licenses.

Mr. Chairman, I could go on with this needs list for quite awhile, but I have probably talked long enough. I do thank you for this opportunity and would be very happy to try to answer your questions.

[Testimony resumes on p. 103.]

[The prepared statement of Mr. Kuriansky follows:]

TESTIMONY OF

EDWARD J. KURIANSKY
SPECIAL PROSECUTOR

OFFICE
OF
THE NEW YORK SPECIAL PROSECUTOR
FOR MEDICAID FRAUD CONTROL

Mr. Chairman, Members of the Committee:

I am very pleased to appear before you today to discuss the subject of Medicaid fraud and abuse. It is a special privilege to appear before this committee which, some 14 years ago, initiated the landmark federal legislation that established and funded the national Medicaid Fraud Control Unit Program. Since that time, nearly 40 states have created fraud control units and well over 5,000 arrests of corrupt medical providers and vendors have ensued -- prosecutions that would almost surely not have been brought without this vital piece of legislation. In a very real sense, the Medicaid Fraud Control Unit Program now fills a pivotal role in the surveillance and enforcement of this nation's health care industry, much as the IRS and SEC have long served as an integrity check on our taxing and securities systems.

Medicaid, of course, is the primary government health-care program for 28 million of America's poorest and oldest citizens. On a national level, Medicaid expenditures totaled more than $60 billion last year, and will cost well over $70 billion this year. While most of these taxpayers dollars go directly toward providing needed medical care for the intended beneficiaries, a tremendous amount is lost to fraud and abuse year after year as the Program continues to offer the kind of sizeable cash rewards that attract predatory -- and extremely cunning -- providers. Regrettably, the Medicaid Program, at age 25, must be seen as a program that has all too often failed, certainly not in its ideals, but in

its execution -- a program of too little access, too little quality, and far, far too much abuse.

For over ten years now, numerous Congressional, governmental, and private insurance groups have consistently estimated the amount of fraud and abuse in the Medicaid Program, and indeed in our health care system in general, at somewhere between 5% and 25% of total expenditures. And while there may be no way to put a precise figure on it, we are certainly talking about many hundreds of millions, and most likely billions, of dollars.

Medicaid fraud is certainly no stranger to New Yorkers, who, as far back as 1974, were rocked by a nursing home scandal of immense proportion. Allegations of patient abuse, theft, and official misconduct were reported daily in the mass media and led to universal outrage and a demand for effective redress of these systemic and widespread problems. In response, New York became the first state in the nation to appoint an independent Special Prosecutor to investigate and prosecute nursing home fraud and abuse, and the organization of this Office -- namely, a coordinated team of lawyers, investigators, and auditors operating separately and apart from the single state agency that administers the Medicaid Program -- ultimately provided the Federal statutory model for the national Medicaid Fraud Control Unit Program. In May 1978, the Special Prosecutor's Office was officially designated as New York's Medicaid Fraud Control Unit,

and is now the largest statewide operation in the country dedicated exclusively to the investigation and prosecution of health care crime.

Since the inception of this Office in January 1975, through December 1990, its investigations have resulted in the arrest of over 1700 defendants, with an overall conviction rate of 92 percent. In addition, the Office has instituted the recovery of more than $131 million in overpayments, fines, and restitution. In the past four years alone, we pursued over 4300 investigations that led to the prosecution of more than 600 defendants for the theft and attempted theft of nearly $62 million from the Medicaid Program. During this same period, court-ordered criminal restitution exceeded $18.4 million, criminal fines totaled nearly $2 million, and civil judgments and recoveries totaled more than $27.7 million.

As the investigative agency primarily responsible for monitoring the $14 billion annually spent on Medicaid in New York State -- approximately 20% of the nation's total -- we have been witness to some of the largest and most sophisticated frauds ever committed against the Program.

During the past decade, in particular, we have literally seen a feeding frenzy on the Medicaid Program, a period of unprecedented white-collar 'wilding' in which wave after wave of multimillion dollar fraud has swept through nursing homes and hospitals, to clinics and pharmacies, podiatry and DME, radiology and labs, and more recently,

home health care. Each surge has brought its own special brand of profiteer in search of the next great loophole in the Medicaid system.

Perhaps the most notorious case of all was that of Sheldon Weinberg and his two sons, Jay and Ronald, who systematically looted more than $16 million of the $32 million their Brooklyn health care center received from Medicaid for supposedly treating the City's poor from 1980 - 1987. The Weinbergs' scam involved falsely billing Medicaid for close to 400,000 phony patient visits, first by paying a clinic dentist on a percentage kickback basis to do nothing but fabricate and file fraudulent Medicaid invoices, and then, at its height, by actually programming a computer to generate bogus claims and backup medical charts for as many as 12,000 fictitious patient visits a month.

In November 1988, after a five-week jury trial, the three Weinbergs were convicted of this 'megalarceny'. Six weeks later, however, on the eve of sentencing, we received an anonymous tip that Sheldon Weinberg, then at liberty on $250,000 bail, and his wife, Roslyn, had fled the $5,000-a-month home they were renting on Long Island. Agents dispatched to the location found an empty safe and a house stripped of all personal belongings except monogrammed towels taken from Manhattan's Helmsley Palace Hotel and 25 pairs of shoes.

The next morning, Jay Weinberg was sentenced to a maximum term of 8 1/3 to 25 years in jail, and his brother, Ronald, to a term of 5 to 15 years in prison. Their

missing father was sentenced in absentia to 7 - 21 years, and a bench warrant was issued for his arrest.

Fortunately, however, Sheldon Weinberg's flight from justice proved to be surprisingly short-lived. As a direct result of viewers' tips within hours of a specially broadcast re-enactment of his crime on NBC-TV's "Unsolved Mysteries" in May 1989, he was located and apprehended before dawn in Scottsdale, Arizona -- notwithstanding the fact that he had, in the interim, grown a beard, entered into a sham Las Vegas marriage, and assumed a new identity.

It was somehow fitting that ordinary citizens, whose millions of stolen tax dollars directly financed Weinberg's obscenely lavish lifestyle -- that included an $18,000-a-month apartment in Manhattan's Trump Tower, a $5 million golf course and lakefront mansion in Boca Raton, Florida, yachts, and a fleet of custom cars -- should be the instrument of his ultimate downfall.

While the Weinbergs may have committed the single largest Medicaid fraud in American history, they certainly had no corner on the criminal market. Throughout the 80s we found:

-- nursing home operators and hospital administrators taking kickbacks from facility vendors as well as charging off personal luxury items on Medicaid cost reports;

-- we found nursing homes discriminating against Medicaid recipients by demanding unlawful payments in return for admission and by simply 'dumping' them in favor of higher-priced private patients;

-- sadly, we continued to find isolated, though not infrequent, instances of nurses, aides, and orderlies raping, sodomizing, beating, kicking, and force-feeding the helpless, often incompetent patients in their charge;

We also found:

-- pharmacists shorting and 'fattening' prescriptions; substituting generic drugs for brand names; buying up forged script and resold drugs; and creating telephone refill orders out of thin air;

And then there were the physicians. We found:

-- doctors charging for nose jobs, abortions, and allergy, hearing, heart, lung, and range of motion tests they never performed;

-- doctors billing while they were away on vacation or out sick, billing in the name of other doctors dying of AIDS, and even double billing for autopsies;

-- podiatrists charging for foot surgery when they were actually giving pedicures and trimming toenails;

-- pediatricians billing as psychiatrists and psychiatrists time-beating their patients;

-- all sorts of doctors splitting fees in return for rent, demanding under-the-table cash payments from Medicaid patients, and taking kickbacks -- millions in kickbacks -- in exchange for ordering everything from drugs and sonograms, to blood tests, orthopedic shoes and durable medical equipment.

We also found:

-- doctors practicing without licenses and altogether unqualified personnel posing as doctors and prescribing medication, and, in one case, even giving therapy and hormones to transvestites;

-- and, finally, we found complete 'phantoms' -- nonexistent doctors, dentists, shoe stores, and clinics -- that had been fraudulently enrolled in and were banging away at the Medicaid Program for hundreds of thousands of dollars.

Even more striking than any of these individual scams, however, has been the changing face of the Medicaid cheat over the past ten years. By the mid-1980s, indeed paralleling the rise of Wall Street's infamous insider traders, we had begun to see in New York the emergence of a different kind of Medicaid entrepreneur -- the young professional seemingly without ethical standards and determined to bankroll his medical education and early career at taxpayer expense. His schemes were more ambitious, more complex, and more costly to the public than those of his predecessors. It is interesting to note that in 1975, 65% of those we prosecuted -- mainly nursing home operators and

vendors -- were in the 50-60 year age group. By the late 1980s that figure had dropped to 26%, while those in the 30-40 year age group rose from 27% to 64%.

The archetype of this yuppie thief was Dr. Jeffrey Simon, a podiatrist and owner of five orthotic labs in suburban Westchester and Rockland county, who masterminded the biggest and most complicated podiatry fraud yet perpetrated on this nation's Medicaid system. During his four-year scheme, he billed Medicaid for nearly $2 million worth of expensive custom-made foot appliances -- inlays, arch supports, plates and molds -- while actually providing recipients with cheap stock goods or nothing at all. He recruited young graduates fresh out of podiatry school to assist him, paid kickbacks to dozens of New York City-area podiatrists for 'steering' business to his labs, filed tens of thousands of false claims for useless orthotics, fine-tuned his scam on a yearly basis to evade increasing government scrutiny, and finally, even created a 'mock' laboratory in his office basement, complete with tools, leather dust and foot molds of his own employees' feet, in a last ditch effort to dupe State inspectors. On August 11, 1989, Simon was sentenced to 3 years in state prison.

Simon was certainly not the only one to happen upon this scam. For instance, in December 1989, 9 New York City-area podiatrists were similarly indicted for stealing over $100,000. What made this case particularly disheartening, however, was that it included four professors and a former dean who served on the faculty of New York's only

podiatric college and were entrusted with shaping the medical and ethical standards of young students and future doctors.

In addition, we often found retail shoe stores working in tandem with and paying off corrupt podiatrists. The doctors would routinely prescribe expensive and unnecessary orthopedic footwear for 1000s of Medicaid recipients, and the stores would just as routinely issue them cheap sneakers and fashion shoes. So flagrant was the practice that one podiatrist even went so far as to hand out leaflets in the neighborhood reminding parents to 'get back to school shoes' for their children.

A typical roundup in November 1986 netted 24 defendants who operated 10 shoe stores throughout New York City and had stolen nearly $1.6 million from the Medicaid Program. In over 50 'shops' of these stores, our undercover agents were never once offered orthopedic shoes but rather were told to select a number of pairs of shoes -- depending on the number of prescriptions they had in hand -- from a variety of sneakers, high heels, boots, loafers, and moccasins on display.

To date, our investigation of podiatrists, orthotic labs, and orthopedic shoe vendors has resulted in criminal charges against 186 defendants for stealing nearly $29 million from the Medicaid Program. Of the one hundred sixty-six (166) cases completed so far, there have been 163 convictions, 2 acquittals, 1 dismissal, and more than $24.6 million in court-imposed fines and restitution.

Equally important has been the dramatic decline in annual Medicaid expenditures in the aftermath of this enforcement activity. Indeed, prescription footwear payments dropped from nearly $30 million to $3 million a year, and podiatric service claims fell from $35 million to $13.4 million a year -- a saving to Medicaid of perhaps as much as $240 million in the past five years.

From the mid-1980s forward, an even more fundamental change took place in the operation of inner city Medicaid 'mills' and ancillary providers that has led to a frightful expansion of illegal activity. I refer specifically to the rise of a new breed of Medicaid profiteers who thrive on the multiple, often hidden ownership of clinics that constitute nothing more than barely furnished, utterly inadequate medical facilities and that are often incestuously associated with pharmacies suited to little else than rapidly dispensing massive quantities of drugs and high-cost Medicaid items. Kickbacks by these pharmacies, as well as by clinical labs and DME suppliers, typically create a powerful incentive to unconscionable overprescribing by the practitioners. Moreover, these providers are, increasingly, of foreign extraction with the ability, at first sign of trouble, to return to their homeland enriched with thousands, even millions, of taxpayer dollars. Indeed, many of our defendants and potential targets have been traced in recent years to Pakistan, India, Malaysia, Israel, Ghana, Nigeria, and Haiti. As a rule, too, these entrepreneurs do not themselves come in direct contact with the daily operation of the mills and often use

centralized, computer-directed billing systems. They hire physicians' assistants and unlicensed staff to run their assembly-line operations, move them around rapidly, and change ownership structures frequently. They have learned, largely from prior publicity, that by insisting on cursory patient examinations, blood tests, and occasional x-rays, they can virtually shield themselves from prosecution for state drug violations. In addition, these sophisticated providers know that repeated medical testing under less than optimal conditions poses a health danger to undercover agents and may thereby discourage clandestine probes.

Furthermore, violent crimes such as arson and the possession of deadly weapons are now often part and parcel of traditional white-collar larceny schemes and, whereas only a few years ago Program thefts generally ranged in the area of $50,000 - $100,000, Medicaid frauds now frequently total a million dollars and more. These new businessmen -- unlike their nursing home owner forebears -- are in business for the sole and exclusive purpose of exploiting the Medicaid Program and have no interest whatsoever in delivering real medical care to real Medicaid patients.

Such was certainly the case of Dr. Surinder Singh Panshi, who spearheaded perhaps the most nefarious fraud ever perpetrated on this country's health care system: namely, the illegal trafficking in human blood for millions of dollars in profit.

The preliminary findings in this case shocked even our most seasoned investigators who, in early 1988, were advised by nurses at a local methadone clinic that their Medicaid patients would no longer allow blood to be drawn for testing purposes because they had discovered several Bronx locations where they could sell their blood for $10 - $20 a half-pint.

At the same time, physicians in the emergency room of Manhattan's Columbia-Presbyterian Hospital reported treating several previously healthy young patients who required hospitalization and massive transfusions for life-threatening anemia and who acknowledged having sold half the blood in their bodies to these Bronx collectors.

Shortly thereafter, we executed search warrants on three Bronx tenement apartments and seized over 1,100 vials of unidentified blood, hundreds of empty vials and needles, rubber gloves, needle cutters, tourniquets, a centrifuge, and a sawed-off shotgun. Subsequent testing of these blood samples revealed the presence of both the AIDS (HIV) and Hepatitis B virus.

The investigative trail eventually led to a 'blood trafficking' ring run by Pakistani and Malaysian immigrants and secretly controlled by Surinder Singh Panshi -- a defrocked doctor and previously convicted Medicaid provider -- and his 68-year-old father, Gurdial Singh Panshi.

Their elaborate empire extended from the dirty and dangerous blood-drawing depots they established in the Bronx, to 'shell' management companies set up in Brooklyn to do nothing but buy, collect, and package illicit blood, to full-scale clinical testing laboratories in Queens and Long Island that they controlled and billed through.

They brazenly urged any accomplices who attracted law enforcement 'heat' to flee the U.S. for their native Pakistan -- as five actually did -- and their scheme was so detailed that the size of kickbacks paid to their assorted 'salesmen', 'consultants', and 'blood collectors' even fluctuated according to market conditions, such as the current supply and demand for 'street' blood, whether the blood was accompanied by a real Medicaid recipient's name, and whether the purported referring doctor actually worked at the address listed on the lab test order form.

Panshi 'salesmen' regularly picked up 150-200 vials a day per depot and paid the collectors $25 for each vial -- prepackaged with a phony lab test request form, a forged physician signature, and a bogus Medicaid recipient name and number. The labs then ran the blood through testing machines to create a fraudulent 'paper trail' and billed Medicaid for batteries of high-priced and utterly useless tests.

In August 1988, Dr. Panshi, his father, eight other individuals, and three clinical laboratories were charged with stealing more than $3.6 million -- the largest Medicaid lab fraud in United States history.

Time magazine said of the Panshis' scheme:

"The crime was perfect only in its ghoulish symbolism: the perpetrators allegedly drew blood from poor people, paying them as little as fifty cents a vial, then falsely claimed the samples came from Medicaid patients and billed the government for millions of dollars' worth of bogus laboratory tests."

'Billed the government' was something of an understatement! In fact, in the 30 months prior to their indictment, total Medicaid claims from the three Panshi labs exceeded $31.6 million, and accounted for 20 percent of all Medicaid billings by the State's nearly 450 laboratory providers. Moreover, in that same period, statewide Medicaid billings for medical laboratory services soared from $70 million in 1986 to almost $170 million in 1988.

Less than a year after his arrest, Dr. Panshi pleaded guilty to the entire 127-count felony indictment against him and was sentenced to 5 - 10 years in prison. In December 1989, the New York City weekly, The Village Voice, bestowed on him the dubious title of "Criminal of the Decade".

On a positive note, however, Panshi's jailing, together with a series of tough administrative actions and two follow-up federal-state lab 'sting' operations, have had a demonstrable deterrent impact: Medicaid expenditures for clinical lab services in New

York have now plummeted from a high of $170 million three years ago to a projected $55 million this year.

Yet, for every loophole in the system we close, the voracious provider seems to find another. Only two weeks ago, we arrested a Queens radiologist and three associates for stealing over $1 million from the Medicaid Program by repeatedly billing for 1000s of medically unnecessary, duplicative, forged, and largely unreadable sonogram tests. During the doctor's 2-year scheme, his Medicaid billings jumped from $8,300 in 1987 to over $2.2 million in 1989, and he allegedly paid huge kickbacks to more than 50 so-called sonogram 'salesmen', who arrived daily at his office toting shopping bags full of phony sonograms.

And earlier this summer, a self-employed Queens cab driver, Abdul Majeed, was sentenced to a year in jail after he admitted fraudulently billing Medicaid $150,000 for bogus ultrasound tests. He carried out his scheme by taxiing junkies from Harlem to his Queens apartment, paying them $10 each to lie down and pose for useless sonograms, and forging doctors' and recipients' names on test request forms.

These cases were among five major prosecutions of radiologists, cardiologists, and ultrasound companies brought this year alone that charge 28 defendants with more than $12.5 million in State Medicaid and tax frauds. They appear to be only the tip of the

iceberg in what may well turn out to have been a $75 million ripoff in the ultrasound industry as the 1980s came to a close.

As for the decade of the 90s, it is already presenting serious new challenges to the integrity of the Medicaid Program -- not the least of which may be the gathering storm of home health care. It is already the fastest growing part of our Medicaid-funded health care system, and in New York alone has ballooned from a $400 million to a $2 billion-a-year outlay in less than five years. It is clear, therefore, that we will have to scrupulously monitor the fiscal integrity of this exploding industry, but, at the same time, we must remain keenly alert to the quality of care, or lack of care, delivered to this homebound and extremely vulnerable population. We in New York have only just begun to scratch the surface of this industry's potential criminal activity, but, have already uncovered 3 'megalarceny' Medicaid frauds totaling more than $7.5 million. And not only are these defendants charged with grossly inflating the number of hours their employees worked, but, more importantly, with recklessly sending untrained, unqualified, and unlicensed aides into the private homes of thousands of critically ill and care-dependent patients. This is surely an area that will bear serious watching.

But perhaps our most pressing concern today in New York is a recent phenomenon known as 'playing doctor' that involves a vast network of Medicaid physicians, pharmacists, and recipients engaged in the blatant dealing of drugs and script

for cash on the black market. Unlike many of the earlier frauds, this one is as much driven by recipients and their desire for drugs as it is by corrupt providers.

As we speak, this scam is plaguing ghetto communities throughout New York City and probably costing taxpayers upwards of $150 million a year. In this illicit underground economy, abusive recipients -- often drug addicts -- 'burn their card' (which means quickly running up $20,000 - $50,000 in Medicaid charges) by visiting unscrupulous doctors and obtaining utterly unnecessary prescriptions for a laundry list of medications.

These physicians operate out of seedy storefront offices that resemble fortified prison cells, and they often examine -- or rather question -- their so-called 'patients' via telephone through windowed wall partitions. Invariably these days, the patients request script for noncontrolled, high-cost brand name drugs. They know exactly what 'buzz' words to utter and symptoms to describe -- ulcers for Zantac; allergies for Seldene; depression for Prozac; backache for Feldene -- so that the doctor has just enough medical justification to issue the fraudulent prescriptions. In some instances, the doctor's receptionist or security guard will even tell the 20 - 30 patients crowded in the waiting room what they should say is ailing them and what the doctor is willing to write that particular day.

With his prized prescriptions in hand, the patient then either 'busts the script' by selling it to an accommodating pharmacist or has the prescription filled and sells his drugs

for cash to so-called 'nonmen' -- i.e., the buyers of noncontrolled substances -- who lurk nearby in the street. The patient will generally net 5% - 10% of the drugs' retail cost -- usually $10-$20 -- and thus get the pocket money he needs to buy crack, alcohol, or other substance of his choice. This is why scores of patients will gather in long lines as early as 5 or 6 in the morning and wait hours for a momentary visit with the doctor and why patient after patient reports identical symptoms.

The 'nonmen' and their 'runners' then bring their wares to other, larger-scale collectors and wholesalers, who in turn resell the drugs to local pharmacies and discount stores, or sometimes even distribute them out of state or country to Caribbean-basin areas such as Puerto Rico, the Dominican Republic, and Colombia. As for the clinic owners and doctors, they receive some money by directly billing Medicaid for the patients' office visits, but most of their profits come in the form of kickbacks from the pharmacies, labs, sonogram firms, and DME suppliers whose expensive services they unnecessarily order. Indeed, the doctors will often not even issue prescriptions to a patient unless he is first willing to submit to costly and invasive procedures -- such as blood drawing and x-rays -- that, as I have mentioned, have the additional advantage of weeding out potential undercover operatives. Thus, each of the players in the scheme -- the physicians, the pharmacists, the recipients, the nonmen, and their bosses -- gets his own generous slice of the Medicaid pie.

In closing, I must emphasize that this ongoing spectacle -- in and about ghetto clinics and pharmacies -- of long lines of drug abusers, who seek not to obtain legitimate medical care but rather to sell their Medicaid cards or medications for cash, cannot be adequately addressed by criminal investigation and prosecution alone. A genuine solution to this Medicaid fraud-drug diversion epidemic, as well as many of the other abuses I have described today, will require a vigorous and broad-based response by all state and federal legislative, administrative, and regulatory bodies that oversee the Medicaid Program and its participating providers.

As long as Medicaid remains essentially a fee-for-service program that grants patients freedom of medical choice and depends largely on provider honesty, state prosecutors and administrators nationwide will require a vast array of surveillance and enforcement tools:

1) Since it is the physician's power to write script and demand kickbacks from other providers that fuels so many of the more flagrant abuses, we need the same tough felony kickback statutes and realistic immunity and accomplice corroboration rules that already exist under federal law;

2) To deal, in particular, with the ongoing hemorrhaging caused by the 'playing doctor' scam, we need new state and federal laws specifically prohibiting the resale, repurchase, and redistribution of Medicaid drugs and supplies;

3) We need a mandatory photo I.D. program to help curb the illicit sale, purchase, rental, and theft of Medicaid cards, practices especially rampant in large urban areas;

4) We need utilization thresholds to restrict, at least somewhat, the number of doctor visits, prescriptions, lab tests, and DME supplies a recipient can receive without prior state authorization. It is simply intolerable that Medicaid could -- as has happened in New York -- be billed in the name of a single Medicaid recipient in a single year for $170,000 worth of AIDS medication, or $50,000 in blood tests, and or for a $90 sonogram each and every day of the year;

5) We need to impose a strict prior approval system on all 'big-ticket' DME items such as prescription footwear, orthotics and prosthetic devices, wheelchairs, seat lifts, and breathing equipment;

6) We need to require performance bonds or other financial security from high-volume providers so as to discourage hit-and-run assaults on the Program by those who, once caught, might be tempted to abscond the jurisdiction or secrete their assets abroad;

7) We need to institute, as in Medicare, an aggressive EOMB, or confirmation of benefits process, because, more often then not, Medicaid recipients are utterly unaware of the fraudulent and inflated claims doctors and pharmacists are making in their names;

8) Until Medicaid moves more broadly toward an HMO or other managed-care treatment modality, we need to consider eliminating or severely limiting certain optional, especially fraud-prone services such as podiatry and audiology;

9) We need to tighten up provider enrollment procedures so that we know right from the outset at least as much about a prospective Medicaid biller as we do about the typical applicant for a driver's license;

10) We need to consider implementation of: a) a certificate of need (CON)-type process -- as with nursing homes and hospitals -- for enrolling individual providers based on actual community need, and b) a competitive bidding process for contracting out all Medicaid work in certain limited categories (e.g., blood testing) to a very select number of respectable providers;

11) And we need to streamline and toughen up the physician disciplinary process so that assembly-line, pill-pushing practitioners are treated as a serious menace and those convicted of felony frauds are stripped -- like lawyers and nursing home administrators -- of their professional licenses.

Mr. Chairman, I could go on with this 'needs list' for quite awhile, but I am sure I have already exceeded my time. I thank you again for this opportunity to appear before you and would be happy to try to answer any questions you may have.

Mr. DINGELL. Mr. Kuriansky, the committee thanks you for a very helpful statement. The Chair wants to commend you as the special prosecutor for Medicaid fraud control in New York for not only an outstanding job but also for great assistance to the committee.

As you have been going through your comments, we have been making very careful notes of your suggestions and the points raised with an eye towards dealing with them legislatively at the earliest possible time, so I want you to know that your help has been very substantial.

Mr. Anderson, you have sat there very patiently. We would like to hear any comments you would like to make.

Mr. ANDERSON. Mr. Chairman, I think Mr. Kuriansky quite eloquently put forth the needs of Medicaid fraud units in the country.

I have no prepared statement. I will be glad to entertain any questions you might have.

Mr. DINGELL. Very well.

The Chair is now going to recognize the distinguished gentleman from Georgia for the purposes of such questions as he deems appropriate.

Mr. ROWLAND. Thank you, Mr. Chairman.

Mr. Anderson, or anyone else at the table, why are certain controlled prescription drugs increasingly popular?

Mr. ANDERSON. Sir, there is a variety of reasons for that.

First, I think a large part is due to the AIDS epidemic. It is causing some people to turn away from needle drugs. People on needle drugs find that certain drugs that they take, like Xanax, will actually summit the high they get with methadone.

I think Mr. Koppelnick could probably give you a more graphic description of why some of these pills are popular, but another reason we have touched on briefly here this morning is the financial benefit people can get from in turn selling the controlled drugs that they get with their Medicaid prescriptions.

In Maryland, for example, I believe Xanax goes for $2 or $3 a pill. In New York it is considerably higher than that. So a person with a medical assistance card can go into a doctor's office, get a prescription, go to a pharmacist and pay nothing more than a 50 cent co-pay, and get 30 to 90 Xanax pills which they can then turn around and sell on the street for $3, $5, to $5 a pill.

Jan, do you have anything to add to that?

Mr. KOPPELNICK. You are a doctor, aren't you, Mr. Rowland?

Mr. ROWLAND. I am.

Mr. KOPPELNICK. Well, you know oral admission now is the thing because of the AIDS epidemic; dope fiends are scared. I mean, I don't have the answer to cocaine, don't ask me about cocaine; but you know the potentiating effect of Xanax, Phenergan, Ativan, Valium, Placidyl to the opiated drugs.

I can be dipping right here; you know that, and I know it.

In Maryland, of course, you can call them in. We don't have a triplicate in Maryland.

Like Mr. Anderson said, for 50 cents, I can get 100 Xanax and sell them for $2.50 in 15 minutes at Lexington Market, if you are familiar with the area in Baltimore.

Any anti-anxiety drug is going to potentiate the effect of a narcotic.

Mr. ROWLAND. You mentioned some of the financial returns. I guess the financial returns for Medicaid recipients, then, are pretty big when they sell these drugs on the street.

Mr. KOPPELNICK. Absolute. I can make $1,000 a day if I want to beat my brains out for about 8 hours, if I can make four doctors—you know what I mean by making four doctors, if I would go to you as a kidney stones with the blood, drip it in the—or encephalitis with the——

Mr. ROWLAND. I have to tell you a little story about that. I had a patient who was complaining with kidney stones and went in to get a urine specimen.

And he had a little piece of beef he dropped in, squeeze a little blood out of it, but unfortunately some of the muscle from the beef got in. When I looked under the microscope, there was some muscle in there.

So I am very much familiar with some of the things that they try to pull in order to get what they are after.

Profits are pretty high for doctors and pharmacists who defraud the system also.

Mr. KOPPELNICK. Absolutely. I mean, you are talking about—you are billing, like if you have a managed care card like somebody like me usually has a managed care card, you are familiar with what I mean?

I can limit it to one pharmacist, one doctor or an ES-2, if I have to go to a specialist, ES-2's send me a recommendation. So let's use my hypertensive medication, for example, Clonidine. It's made by Warner Chilcott Company. It is $47 a hundred by Warner Chilcott, $12 by Barr.

If I am locked into one pharmacist and they say they don't have it, generically they can give me the Warner Chilcott on $47 a hundred.

What did he make, probably $20, $30, $40, and you know they do that. They might carry 500 Barrs and maybe 10,000 Warner Chilcotts, just using Clonidine, for example, not being a CDS, and it is a very popular anti-hypertensive drug.

Mr. ANDERSON. On top of that, Mr. Rowland, we have a physician who has done nothing more in many cases than write a prescription, and he will bill Medicaid for a comprehensive or extended office visit.

Mr. ROWLAND. Let me ask you in that respect what is the typical profile of a physician who abuses these prescribing privileges? Do they have a typical profile that tips you off?

Mr. ANDERSON. The only thing that we found that is typical is they tend to be inner-city, and they tend to have a very high Medicaid practice, but they have cut across all age groups.

We recently are seeing what Mr. Kuriansky referred to, the young entrepreneurs who are new into the business. They cut across all races. We haven't seen something typical. Perhaps Jan could enlighten us on what he has found to be typical; but from the law enforcement standpoint, they have cut across everything.

Mr. KOPPELNICK. I get over, Mr. Rowland, because of the way I look and my age, and I can—you know, I can say I am allergic to phenathiazines.

You are a doctor, so maybe I am—I can corner you, maybe not you, but I can corner a physician into certain drugs that I am going to get. I am allergic to this, I know what I need to say for that, and, I mean, it's going to work.

And he is getting $42 for an office visit. He wants me out of there. Sometimes he doesn't even have to write it out. He's got the stamp. He doesn't even feel like writing his name.

It's a joke. I mean, they don't even want to write their name they are so busy. They have six people in different offices, I mean, different waiting rooms.

Mr. ROWLAND. What about the pharmacist? Is there a profile that fits the pharmacist?

Mr. KOPPELNICK. Not in Baltimore. In Baltimore it's unbelievable. The chains will do it. I mean, there is so much money in prescription medications, I mean, that's how they make their money.

You bring them in the door that way.

Mr. ANDERSON. Pharmacists are under professional obligation to question prescriptions that they think are suspicious.

However, it's been our experience that in talking to pharmacists, particularly under oath and the grand jury, that they will tell you that they would never second guess a doctor unless they have real good cause to think a doctor is committing a fraud or, in fact, dealing in drugs.

It's very rare that a pharmacist will turn away a client or a patient.

Mr. ROWLAND. What about a prescription that illegally abuses his prescribing privileges? We control licensing at the State level. Tell me what happens when they are caught. Do they automatically lose their license or what?

Mr. ANDERSON. Not in Maryland. I think probably not in most States.

In Maryland you automatically lose your license to practice medicine if you commit Medicaid fraud and you are convicted of it or you plead guilt to it. But that is not necessarily true if you abuse your prescribing practices.

It's a decision made by the licensing body for physicians in Maryland that in Maryland consists of civilians, as well as physicians, but it's not an automatic revocation.

Mr. DINGELL. Would the gentleman yield?

What you are telling us, I think, Mr. Anderson, is that the doctor automatically loses his license if convicted.

Mr. ANDERSON. Of Medicaid fraud or pleads guilty, yes, sir.

Mr. DINGELL. I beg your pardon?

Mr. ANDERSON. Or pleads guilty to Medicaid fraud.

Mr. DINGELL. Now, with regard to others, that is dealt with by the responsible licensing and the regulatory body, for example, in the case of laboratories, the pharmacists.

Mr. ANDERSON. That is right.

Mr. DINGELL. People who would prepare foot orthotics or something of that sort, is that right?

Mr. ANDERSON. That is correct.

Mr. DINGELL. How often does a State licensing body take action against somebody who has been convicted?

Mr. ANDERSON. I must be candid and say that Maryland is very poor in this regard. I think we were recently ranked——

Mr. DINGELL. Beg pardon?

Mr. ANDERSON. Maryland is very poor in this regard, in all candor. The licensing bodies are often very slow to react to issues of prescribing abuse.

Most often what happens is the physician is ordered to undergo training or retraining with monitoring by his fellow physicians.

It's very rare that a license will be revoked based solely upon prescribing.

Mr. DINGELL. You're making me think that maybe we ought to address the Medicaid authorization the next time it comes up to provide some sort of stimulus for the States in this matter.

I'm not sure you want to go back to the State having such control, but I get the impression that's not a bad idea.

The Chair thanks my friend from Georgia.

Mr. ROWLAND. Well, I see my time has expired, Mr. Chairman.

Mr. DINGELL. The Chair recognizes the gentleman. He is doing fine.

Mr. ROWLAND. Let me ask you this question, then. I know we have talked about triplicate prescriptions before.

Would the writing of triplicate prescriptions in any way help in dealing with this problem?

Mr. ANDERSON. The Medicaid program certainly in Maryland, and I think in almost all States, is in effect a triplicate prescription program because every prescription that's written finds its way to the Medicaid program for reimbursement.

So we can take the data that's on the prescription, enter it into a computer, and find our own patterns. It's an immense help in these investigations.

Where we fall down on the job in Maryland, and I think in most States, is that we cannot track private pay prescription because there is no copy that's given to the State.

So a doctor that wants to get over on the State or, for that matter, a junky that wants to get over detection merely will pay under the table for a private pay prescription and not use his Medicaid card.

New York, I believe, has a triplicate prescription program.

Mr. KURIANSKY. The reason why the New York providers have now moved toward non-controlled substances is because we are on a triplicate prescription program for the benzodiazapines in New York. We went to that in 1989.

Before then, most of the doctors were writing script for controlled substances, particularly for Valium and Xanax and Ativan.

Once we went to the triplicate prescription program, we found—we saw a drop in Medicaid expenditures for those drugs by about 65 percent, but they then moved to the non-controlled area where they don't run the risk of committing drug violations, bring in the DEA, having the Health Department know exactly what kind of script you're writing.

It has all kinds of advantages for the provider not any longer to be involved in the controlled substances, and we still find it occa-

sionally. But most of these doctors are savory enough now not to bother with controlled substances.

Mr. ROWLAND. What non-controlled substances are attractive?

Mr. KURIANSKY. Well, I mentioned some of them. You've got Prozac, Seldane, Naprosyn, antihistamines.

Mr. KOPPELNICK. Phenergan and Clonidine, especially in Maryland, Phenergan being a potentiator, Clonidine a potentiator.

Well, if you want to go back where you get the, like Vibramycin, for example, the doctor will give you a prescription for the Vibramycin.

The pharmacist will fill it. It's $3 a tablet if they don't have the generic. He will fill it, and you'll sell it back to him for $80, and it goes back on his shelf, and he billed Medicaid for $300.

You can write for 100 Vibramycin. You're familiar with Vibramycin, I'm sure. Phenergan and the drugs this gentleman is talking about in Maryland are not—Phenergan, Clonidine.

We have got a big problem with Schedule 4's and Schedule 5's in Maryland. There is no—the anti-anxiety drugs are the big thing in Maryland.

Mr. ROWLAND. What percentage—do you have an idea what percentage of physicians are involved in this kind of activity intentionally?

Do you have any idea?

Mr. KURIANSKY. I think it's probably a small percentage, and maybe even 5 percent would be too big. I certainly would be surprised if it were 10 percent. But what is significant is the damage that that 2, 3, or 5 percent can do.

Just look at the statistics I cited with regard to the podiatrists. I think we calculated that maybe about 10 percent—I think we prosecuted about 10 percent of the active Medicaid providers, but they were responsible for somewhere between 50 and 75 percent of the Medicaid billings.

The labs are the same thing. There was probably 90 percent of the Medicaid lab billings in one particular year that was fraudulent. It was only submitted by 5 to 10 of the 450 medical laboratories in New York.

So the financial damage that even a small percentage of corrupt providers can do is tremendous.

Mr. ROWLAND. I am interested in your comment a few minutes ago about the Medicaid program and the fact that you thought we ought to look at some sort of managed care or HMO's.

Are you suggesting that the Medicaid program may be so fraud and so subject to abuse that it's not likely that we can find a way to deal with it adequately?

Mr. KURIANSKY. Certainly from a fraud control standpoint, as I said, I don't—there was a time when I first started in this work that I thought we were going to push it into extinction. But I have been chastened since then, and I can see that the problems are only getting bigger every year, really.

As long as it's a provider-friendly system, a system that depends, really, like our tax system does, on the honesty of the people submitting the bills, and particularly with government throwing more and more money at health care, it's going to attract these sharks.

And you cannot prosecute them out of existence, and I really think that from a fraudulent standpoint, obviously there are other medical policy public health issues when you move to managed care.

And perhaps that would bring its own problems in terms of quality of care. And I wouldn't be surprised that even providers under a managed care program wouldn't find some way to cheat, but certainly think the way the Medicaid system was structured back in 1965, giving patients the right to go to the doctor or whatever of their choice, and really giving the billing—putting the billing solely in the hands of the providers without really any checks on them, that it was made for fraud, and the crooks found it.

Mr. ROWLAND. Yield to the Chairman.

Mr. DINGELL. The Chair thanks the gentleman.

Mr. Kuriansky, you have assisted the committee very greatly today, as have you, Mr. Anderson and Mr. Koppelnick. We thank you.

Now, Mr. Kuriansky, why is New York considered the pioneer in terms of prosecution of crimes involving misuse of health care systems like Medicaid and things of that sort?

Mr. KURIANSKY. I think it's fortuitous, actually. We were lucky enough to have this horrible nursing home scandal 15 years ago.

We were thrust into it in a period of tremendous crisis. I mean, it was on the front page of every newspaper on the New York Times, whatever, the nightly news day after day after day long, before even the Congress a few years later caught up and realized that this was not just a New York problem but a national problem.

As a result there was a tremendous demand that we do something about this. And the primary recommendation actually by the Commission that studied it was to create a special prosecutor's office and to adequately fund it to devote it exclusively to this job.

And I think most importantly that the success of our work has been this unified team concept whereby we have in place, as do all the fraud units now, a team of lawyers and auditors and investigators who worked together from day one because we are faced in this business, this is white collar crime, and as you know, white collar crimes can afford the very, very best counsel.

And they move to block your reference at the very outset, the first hint of a subpoena there is a lawyer on the telephone. So we need in place the moment we begin and even before they get wind of an investigation, this kind of a team.

It's very difficult to work it when the prosecutor is in one office and the police is in another office, and they don't even have financial auditors to work with.

This was the real genius, I think, of the Federal legislation that set up the fraud control unit program because it required this kind of an entity to work exclusively on health care, and we have been doing it for 15 years now.

And for better or worse, New York seems to get the biggest and the best of everything, including criminals, and we have certainly had our share.

Mr. DINGELL. Thank you.

The Chair is going to recognize the minority counsel for questions.

Mr. WILSON. Thank you, Mr. Chairman.

I just have one question to follow up on what Mr. Rowland asked.

I would be interested in knowing from all three of the panel members what your thoughts are, from a fraud standpoint, of the advantages and disadvantages of managed care.

I know you alluded to that, Mr. Kuriansky, but I understand, Mr. Koppelnick, that you're now in a managed care program.

So I would be interested in any thoughts Mr. Kuriansky would have in addition to Mr. Koppelnick and Mr. Anderson's thoughts. From a fraud standpoint, how does managed care look?

Mr. KOPPELNICK. I'm finished with managed care. I'm back to, and now you can get around it again.

It's what I do. I know produce and pharmacology. It's what I do. I'm back into what they call a regular red and white card. Blue and white card is managed care.

Mr. ANDERSON. If I could just clarify, we are talking about two different issues here. There is one form of managed care that Mr. Koppelnick is referring to that when the Medicaid program discovers that someone is abusing their card, either to get prescriptions or for office visits or whatever, they will take that Medicaid recipient and require that he or she go to one particular doctor.

That is managed care. But also in Maryland, we have an HMO form of managed care. Mr. Koppelnick is referring to the fact that he has been restricted to one doctor but apparently no longer. He can go to whichever doctor he wishes.

Mr. KOPPELNICK. Even at managed care, I can go to the one doctor, the family physician, who can refer me to the psychiatrist, who can also refer me to the cardiologist.

I can wind up with four doctors even under managed care, and as long as I don't get those same particular prescriptions, and I know which ones to get from who, you know, I can wind up with still a good $25 worth of drugs a month.

Mr. WILSON. So from your perspective, Mr. Koppelnick, as kind of a reformed hard core abuser, if you want to work the system, you can continue to work the system, even under managed care.

Mr. KOPPELNICK. Oh, absolutely.

Mr. ANDERSON. His form of managed care, but in the other form of managed care, the HMO form of managed care that we are talking about, there is no question it would make the commission of fraud much more difficult because services would not be on a per-service schedule.

Mr. WILSON. Maryland is contemplating going to a managed care system statewide for its Medicaid program?

Mr. ANDERSON. That is correct, and I believe Arizona has gone to a managed care program.

Mr. WILSON. That is correct.

Would it be the type that Mr. Koppelnick was on or the HMO type?

Mr. ANDERSON. It would be the HMO type.

Mr. WILSON. So the type that Mr. Koppelnick was on was just for someone who had been identified as an abuser?

Mr. ANDERSON. That is correct.

Mr. MONTGOMERY. When you were on that program, Mr. Koppelnick, was it more difficult to commit—to get additional drugs?

Mr. KOPPELNICK. Slightly. I mean, my managed care doctor was—they brought him down, and he is now, you know, down the tubes.

He is not incarcerated, but, I mean, I was getting—I could tell him—I could get 100 Xanax today, 30 Placidyls, 100 Phenergan and tell him they fell in the toilet tomorrow, and he would rewrite the prescription.

And then I could get a referral to those psychiatrists and a referral to a cardiologist, and, you know, and a neurologist, and I knew what to do, and I knew what to say.

Mr. WILSON. Mr. Kuriansky, do you have anything additional?

Mr. KURIANSKY. We have to really make a distinction between a restricted recipient program under the Medicaid program as it exists now and an HMO managed care system that we may see in the future.

We have a restricted recipient type program in New York also for the really abusive recipients, but we have found some of them really through maladmission assigned, restricted to physicians and pharmacists that are Medicaid cheats.

But it would be different, I think, if the whole program were reorganized and you enrolled, you made a real effort to enroll responsible providers, you gave them reasonable fees, probably far more generous than exist currently, and they knew up front that they were only going to get X number of dollars for the year from Mr. Koppelnick.

And it didn't matter—it doesn't matter how many tests they order or how many visits he has or how many prescriptions they write, they are going to get X, and you take away the incentive they have to bill for unnecessary services.

So from a fraud point, I think the classic managed care program that's being so much talked about today would have great advantages over the fee for service program we have in Medicaid today.

Mr. WILSON. Mr. Chairman, I have no further questions.

Thank you very much.

Mr. DINGELL. The Chair thanks the gentleman.

Now, gentlemen, do all States have these kinds of fraud units, the kind of which you're a part, Mr. Kuriansky?

Mr. KURIANSKY. There are now, I think the number is 39 who have these, and I think we represent, the last number I saw was about 90 percent of the Medicaid billings in the country are covered by States with fraud units.

There are a couple of large States. Actually Georgia, I think, does not have a fraud unit yet, although I understand they have their own very effective enforcement mechanism there.

Missouri is not yet in the program, but by and large, the big Medicaid States all have Medicaid fraud control units now.

Mr. DINGELL. Would we be fair in inferring that a unit of this type is really necessary to maximize chances of successful prosecutions for Medicaid fraud?

Mr. KURIANSKY. I don't think there is any question about it, but it just doesn't happen magically.

There can be fraud units, and there can be fraud units. A Medicaid fraud control unit has to be, number one, adequately funded.

I think you would find when Congress set up this program in 1977-1978, they set a ceiling on the amount of money, Federal money they would pay for.

It was one-quarter of 1 percent of a State's Medicaid expenditures. That does not seem like a whole lot of money to adequately police your Medicaid program, but believe it or not, most of the States—I probably think all of the States are way, way under the cap that was suggested by Congress.

Even in New York, as big as we are, we are probably $20 million—my office probably should be funded another $20 million, twice as much as we are; and we would still be under the cap that was set by Congress.

So I think that's something that ought to be looked at, and I think there ought to be an effort made to urge the States to staff up these units to the ceiling that Congress intended because you're not going to be effective trying to audit a massive hospital or nursing home or one of these complicated kickback schemes if you've got one lawyer and one auditor and one investigator working on it.

I mean, you would use up all your staff on one investigation each year, so, yes, fraud units, I think, serve a tremendous purpose.

As I said, there was nothing being done in health care before the establishment of these fraud units.

Now, somewhere over 5,000 prosecutions have been brought by the fraud units in the last 12 years or so. It wouldn't have happened without them, and I think really—I mean, the FBI and the Federal Government has been getting far more involved in health care.

I know it's a far more important priority to them now than it was earlier, but they have a lot of other priorities they have to work on, too, whereas the fraud units deal only with health care.

And it needs that kind of focused attention. It cannot be a case here, a case there, a splash and then you go away kind of thing.

It really has to be daily, daily work in the industry.

Mr. DINGELL. Can you tell us how long it takes to prosecute the average Medicaid fraud case?

Mr. KURIANSKY. It really depends on the industry you're looking at. I mean, you can send in undercover shoppers to pharmacies, and if they are substituting generic drugs for brand names or adding on additional write-ins to the script, you know, you can probably prosecute them in a month's time.

If you're talking about unraveling the books and records of a massive hospital institution or nursing home, 18 months is probably short.

Mr. DINGELL. What could be done legislatively to enable your kind of unit to decrease the time interval with regard to individuals who commit fraud and can stay in the program?

Mr. KURIANSKY. Well, we have a natural or a problem in that we are part of the criminal justice system. We are prosecutors, and I think you know that the court systems are overworked and underfunded and what have you, so to some extent, our work—I don't know that there is anything that Congress can do to help us any more than they could help the local DA or the local U.S. Attorney.

The process of justice and proving people guilty beyond a reasonable doubt is a very long and painstaking process. I do think, though, that on the administrative end, on—I think I referred in my remarks to some of the things that I thought could be done, that you could stop a lot of this fraud at the front end.

I mean, we as prosecutors are always playing catch-up. The crime is pretty much committed, and then we have to go find it and prove it and prosecute it.

But some of these scams, I think, could have been headed off much earlier.

I mean, the idea that a recipient, as I said, could get away with billing the system—I mean, the average AIDS patient, a real AIDS patient needs about, I think, $6,000 worth of AZT in a year.

We had this recipient in whose name the system allowed to be billed $170,000, the Weinberg case I talked about.

Mr. DINGELL. It would save us about 30 AIDS patients——

Mr. KURIANSKY. It would save a lot of people. It's a terrible waste of money.

From an administrative standpoint, it's a very provider-friendly environment. They are—the administrators, and they have their own biases and job to do. But their job, they see their job as enrolling the recipients, enrolling the providers, and paying the providers as quickly as possible.

Most of the auditing that they do with the screening, the editing of claims is done post-payment, not pre-payment, and as a result we as investigators are also playing catch-up ball.

The horse is already out of the barn, and sometimes the barn is over in Europe.

Mr. DINGELL. He may be headed back for Indiana or Pakistan or Israel or some other place.

Mr. KURIANSKY. That is right.

Mr. DINGELL. With a suitcase bulging with cash.

Mr. KURIANSKY. We probably need Unsolved Mysteries to air in Pakistan. That might help.

Mr. DINGELL. Now, Mr. Kuriansky, we understand that your unit obtained a settlement against one of the Nation's largest publicly owned home health care companies in the sum of about $4 million for false billing for home care services.

Can you describe the case in detail and tell us what you can about this particular case and whether it's indicative of increasing fraud in the home health care area?

Mr. KURIANSKY. I think you're referring to the PCI case, Professional Care, which at the time we investigated and prosecuted them back in, I think it was 1987 and 1988, it was the largest publicly held traded companies, health care company on the market.

And they did ultimately go to trial and were convicted of a $1.8 million Medicare fraud.

It was our first indication that home health care was going to be a problem. It has grown like topsy since then, and just within the past year, we have brought two even larger home health care fraud cases.

And I mean what they are doing, at least on the Medicaid side of it, it may be a little bit different from what Mr. Morey was talking

about with the infusion and the kinds of things that Medicare pays for.

But basically with Medicaid patients, you're talking about billing for hours that aides are not really working. It's a very difficult thing to police, which is why I fear that this is going to be a tremendous problem in the future, whereas with a nursing home or a hospital, in New York, for example, we maybe have a thousand nursing homes and hospitals to focus on.

When you get into home health care, you're talking about 100,000 homes, and to know what's going on in those homes and whether the aides are showing up and whether the care is being given and whether a patient is being beaten or the property stolen, it's a tremendous problem from a quality of care standpoint, as well as a thievery standpoint.

We just brought down—the latest home health care case we brought was the most distressing to me. It hasn't gone to trial yet, but the allegation is that the largest—one of the largest companies in Westchester County, major suburban county in New York State, was sending in totally untrained aides, many of them illegal immigrants who were posing as licensed practical nurses and registered nurses.

The patients in these homes really required that kind of level of care from real nurses, and the people that were going into those homes were these unqualified aides, so—and that was a million-dollar-plus ripoff.

But it carries with it that terrible aspect of the quality of care.

Mr. DINGELL. Thank you. The Chair notes there is a vote going on on the Floor. We will recess for 20 minutes and be back at 35 minutes after the hour. I apologize to you for this inconvenience, and I apologize to the rest of the panel, but there is a vote on and we have to go.

The committee will stand in recess until 35 after.

[Brief recess.]

Mr. DINGELL. The subcommittee will come to order. Yes, thanks for your patience. Is there any way, gentlemen, that this committee or anybody else can estimate the amount of Medicaid fraud that goes undetected?

Mr. ANDERSON. Mr. Chairman, if there is a way I am unaware of it. I think it is a very difficult thing to quantify.

Mr. DINGELL. Mr. Kuriansky.

Mr. KURIANSKY. Well, I think absent of the fact you have some idea about it. I mean, for example, in the areas I described where we intensively investigated. Now, we didn't—let me give you an example. Take labs. We brought prosecutions for, oh, I don't know, $10 or $20 million in Medicaid thefts. But you say the billings drop over $100 million. Anyway it was the same way in the podiatry field. We didn't prosecute all the crooks and we probably didn't know about a lot of them, but the deterrent effect I think showed up afterwards and you get some idea to the percentage of billings that were fraudulent, even if you didn't make cases on all of them.

Mr. DINGELL. Can you give us any idea where we are seeing increased participation of assorted foreign nationals in fraud schemes and what can be done to deter this kind of behavior?

Mr. KURIANSKY. I think the word is just out that Medicaid is a luscious target. We had some, in the Panchee, the blood scam case, we had some under covers with tape recordings in which one of the bosses was describing to a recently arrived Pakistani national that if he couldn't make $1 million off Medicaid in the first year they were going to send him back to Karachi or wherever. I think in some of these places that I know even abroad that the Medicaid program is there.

Same thing with a lot of Russian immigrants. We have got in the transportation industry we are finding, this I think is another rip-off that is coming along pretty quickly. You find certain nationalities, the word spreads among them, that this is a good way to make money in America. And they do. There is a network of recent arrived immigrants, I think they talk to on another. Obviously, I don't want to suggest that is all immigrants talk about, but there certainly is a close network amongst the criminal population.

Mr. DINGELL. Now, you made a number of comments with regard to what could be done in law and regulation to deter fraud and abuse. I am curious, would you want to expand on that with regard to any additional steps that could be taken by the Federal Government that would be of assistance in that undertaking?

Mr. KURIANSKY. Well, I recognize that the Federal Government is unfortunately somewhat limited I guess in what can be imposed on the States.

Mr. DINGELL. The Federal Government can, of course, impose requirements on the States.

Mr. KURIANSKY. Yes.

Mr. DINGELL. We can require that they take certain necessary actions to avoid this kind of rip-off because it is ripping off State money but it is also ripping off Federal money.

Mr. KURIANSKY. Right. I mean I think we are finally succeeding, I think, in New York, for example, on this issue of performance bonding and financial security. I have been urging that for years on our State Medicaid system.

I think, now that might be an area where you could impose as a requirement for a State participating in the Medicaid program that where let's say a Medicaid provider is going to bill the system for $100,000 in a year, that he posts some kind of financial security. That, I think, is very simple. I don't think it violates anybody's rights particularly, and it might be very useful in when they run away or even if you can't convict them or whatever.

At least there is some money to go after and that would, from a solvency of the program viewpoint be very useful.

Mr. DINGELL. You have indicated you made some recommendations regarding the problems you have in terms of getting your recommendations adopted. What has been the cause of the problems in getting these changes that you have suggested over the years and your unit has been suggesting, Mr. Kuriansky?

Mr. KURIANSKY. Well, we have, I think it is a problem in New York, I think it is a problem nationally, although I was happy to hear Dan say that in Maryland a felony conviction for Medicaid fraud means that a doctor loses his license. That is certainly not the case in New York, and I don't think it is the case in many States.

I think there has long been a bias in the medical community that, basically to the effect that a dishonest doctor is not necessarily a bad doctor and a liar and a crook. As long as he doesn't abuse his patients, he shouldn't necessarily lose his license.

That is not true, for example, with lawyers. A lawyer convicted in New York of any felony automatically loses his license to practice law. But not so with doctors. Last time I looked, a couple of years ago, about 75 doctors that we had convicted of Medicaid fraud, I think only 20 of them had lost their license.

And we even found doctors, we had one case where we convicted a doctor, he was thrown out of the Medicaid program but he kept his medical license. So what he did, he continued to see the same Medicaid population. He just didn't bill Medicaid. But he sent all the patients downstairs to the drugstore that his wife ran and she was a registered Medicaid provider and had all the Medicaid prescriptions filled down there.

So he went for the $10 or $15 office visit because he couldn't bill Medicaid, but he still had the medical license that he could write prescriptions. I think weaknesses have been found throughout the country in the physician disciplinary process.

Kick-backs is another one, Mr. Chairman, and I don't know that there is anything that you can really do about that. You have got some very good laws on the Federal books. I wish we had them in the State law. We have drafted a piece of legislation that we are trying to get through to the State legislature in New York now outlawing kick-backs in Medicaid funded businesses, and we are having an awful time getting it through, and I can't, unfortunately use the good laws that exist on the Federal books.

Mr. DINGELL. Did you notice, or can you tell us, whether books and records of persons who provide services as Medicaid providers are open to your scrutiny or open to the scrutiny of Federal investigators or are they closed?

Mr. KURIANSKY. Well, they are certainly open, they are open in the sense we have subpoena power. They are open to the administrative agency.

Mr. DINGELL. You do not have the power to review their books and records at reasonable times and places, or must you resort to subpoena to produce them?

Mr. KURIANSKY. There is a regulation, HHS put out a regulation awhile back which supposedly grants the fraud units, it tells providers that to participate in the program they have to make their books and records available to fraud units within a reasonable period of time.

We have always felt that we do a lot better frankly with, using our subpoena power. By the time that reasonable period of time is up, the books could have been doctored and we are better off going in with certain warrants and subpoenas.

There is something on the books though that actually gives us the right to look at the books and records of Medicaid providers.

Mr. DINGELL. Would you feel that a Federal requirement the States adopt certain penalties and procedures assist in having them adopted and implemented in the different States, including New York?

Mr. KURIANSKY. Could you repeat that? I am sorry.

Mr. DINGELL. If the Federal Government were to adopt a requirement that the States adopt certain penalties and procedures with regard to dealing with Medicaid fraud, would they be adopted in the States and would they be helpful?

Mr. KURIANSKY. I think we probably have to make a distinction between administrative sanctions and penal sanctions.

Mr. DINGELL. I am talking about both.

Mr. KURIANSKY. Because I don't know that you could force a State to adopt penal laws that they are not interested in adopting. As I said, for example, the felony kick-back statute is a perfect example. We need one in New York.

I don't know that you could write a law to force a State to adopt a penal statute.

Mr. DINGELL. We might look at it though.

Mr. KURIANSKY. If you could, that would be great.

Mr. DINGELL. Now——

Mr. KURIANSKY. We also, as I mentioned, we have got very, very tough and restrictive laws dealing with accomplice corroboration and immunity. In the Federal law you have got I think a very sensible use immunity statute. In New York State we have got transactional immunity. It makes it very difficult to penetrate some of these, the hierarchies of some of these criminal families, because everyone you put in the grand jury gets full transactional immunity. Even you could give an immunity bath and you will be in a lot of trouble.

Often our witnesses are accomplices, particularly with these foreign groups. They often insist only on dealing with their fellow foreigners and in a foreign language. Very tough to insert an undercover operative in there.

And yet even when we finally break someone out of the family and he is willing to talk, his testimony in a court of law in New York is pretty useless because of the very strict accomplice corroboration rules.

My office, together with the State district attorneys have been trying for several years now to get, to model the accomplice and immunity laws after the Federal law but we have not been successful.

Mr. DINGELL. Mr. Kuriansky, Mr. Anderson, Mr. Koppelnick, the committee thanks you for your very helpful testimony. I apologize that we had to go over and vote from time to time, but I very much appreciate your presence and assistance to the committee and we thank you very much.

The Chair announces that the next witness is Mr. William J. Esposito, Section Chief, White Collar Crime Section, Federal Bureau of Investigation, Washington, D.C.

Mr. Esposito, welcome to you and thank you for being here with the committee. Mr. Esposito, I am sure you understand all witnesses are required to testify under oath. Do you have any objection to testifying under oath?

Mr. ESPOSITO. No, I do not.

Mr. DINGELL. Chair notes that that being the case you are entitled to be advised by counsel as you appear here. Do you so desire?

Mr. ESPOSITO. No, I do not.

Mr. DINGELL. The Chair notes you have an associate. If you please, sir, could you give us your name?

Mr. FORD. Joseph Ford.

Mr. DINGELL. Mr. Ford, thank you for being with us. Will you be testifying also?

Mr. ESPOSITO. He will be helping answer questions.

Mr. DINGELL. Would you object to being sworn, Mr. Ford?

Mr. FORD. No, sir.

Mr. DINGELL. I can assure you both, gentlemen, in your respective cases, that the procedures will be quite painless and I think you should have no apprehensions on the matter. The Chair advises also that to assist you with regard to your appearance here there are copies of the rules of the House, rules of the subcommittee, rules of the committee to advise you as to the limitations on the power of the committee and the extent of our right as you do appear here.

Gentlemen, if you then have no objection to testifying under oath, if you each please rise and raise your right hands.

[Witnesses sworn.]

Mr. DINGELL. You may consider yourselves both under oath and, Mr. Esposito, we will recognize you for such statement you choose to give.

TESTIMONY OF WILLIAM J. ESPOSITO, CHIEF, WHITE COLLAR CRIME SECTION, FEDERAL BUREAU OF INVESTIGATION, ACCOMPANIED BY JOSEPH FORD

Mr. ESPOSITO. Mr. Chairman, I appreciate the opportunity to appear before your subcommittee to discuss the FBI's criminal investigative division and most specifically the FBI's responsibility and current role in conducting criminal investigations involving health care related fraud.

To avoid any negative impact on pending investigations and expected criminal prosecutions, my statements and subsequent remarks will discuss in general terms the crime problems which affect health care systems in the United States. I hope you and other members of the subcommittee recognize the FBI and Department of Justice are forced to limit our testimony concerning matters that could interfere with the workings of the Federal criminal judicial process. Health care fraud and crimes committed by health care professionals affect our income and imperil the safety of patients.

People stricken with illness seeking medical treatment are the unwitting victims of unnecessary laboratory testing, surgeries, x-rays, prescriptions, supplies, and other ancillary services which defraud the government funded programs and private insurance carriers.

Additionally, these frauds expose patients to treatment which potentially subject them to unwarranted dangers. In 1990 the U.S. Chamber of Commerce calculated that health care costs totaling approximately $666 billion. The United States Chamber of Commerce estimates that health care costs will surpass the $1 trillion mark by 1994. The Department of Health and Human Services

projects that health care spending will exceed $700 billion in 1991 and reach $1.6 trillion by the beginning of the 21st century.

HHS also calculates that by the year 2000 health care will consume up to 16.4 percent of the Nation's gross national product. Of particular concern to the FBI is the Chamber estimates that between 5 to 15 percent of all paid insurance claims currently paid are fraudulent. This statistics indicates a significant loss to the industry which leads to higher insurance premiums. This loss and losses to taxpayers in the form of fraud against the government-sponsored health care programs directly challenges law enforcement to address an entrenched crime problem.

Health care fraud is a criminal activity which is committed both by highly educated professionals and specialized business entities.

The FBI's white collar crime program as well as the Attorney General's economic crime council considers investigation and prosecutions of health care fraud as a top national priority along with financial institution fraud and frauds involving the Department of Defense.

Based upon analysis of previous investigations and criminal activities that have been exposed through ongoing health care initiatives I can state with very few exceptions that health care fraud occurs in almost every segment of the health care industry.

Fraud has been covered in hospitals, nursing homes, clinics, pharmacies, and rolling laboratories and has been committed by durable medical equipment companies and suppliers, pharmaceutical sales representatives, medical testing laboratories and others who provide services to health care professionals and institutions.

The FBI's initial investigations into health care fraud during the 1970's were viewed favorably by the criminal justice system because new investigative ground was being broken. But there also was some limiting aspects.

First, the investigative efforts were restricted to just a few FBI offices. Second, these investigations were almost exclusively traditional in that criminal allegations were resolved through overt investigative techniques such as document analysis and interviews and lastly, although indictments and prosecutions were successful, convicted health care professionals received relatively light sentences for their criminal acts.

During the past 5 years the FBI has elevated health care fraud to an investigative priority and has taken steps to address this criminal problem. The FBI investigation of health care fraud has become less localized, more coordinated and pursued nationally.

In over 30 field offices of the FBI we have identified health care costs and attendant fraud as egregious during the 1980's. To combat health care fraud in these areas of the United States FBI headquarters managers and field office managers have developed an aggressive training program, closer working relationship with Federal and State law enforcement, including regulatory agencies, a coordinated effort with private industry, expansion of the criminal intelligence base, and an increased determination for investigation and prosecution. While it was easy to identify the few FBI offices which investigated health care matters a decade ago, the present day health care effort involves participation by all of our

offices with a focus on investigations of a larger regional and national crime problems.

The FBI's health care investigations have become more effective with greater emphasis on using both sophisticated and proactive investigative techniques. While the FBI continues to produce single defendant prosecutions, a significant percentage of our investigative resources are now committed to cases involving multi-defending conspiracies, for example, the Detroit field office has actively pursued health care fraud investigations during the past 8 years. Through this 8-year period of investigative effort, the Detroit office has established an intelligence data, intelligence base of data and trained investigators. As a result, the FBI Detroit investigations have led to over 700 convictions of licensed providers and health care facility owners.

Using the Detroit success as a model, the FBI's current philosophy includes analyzing emerging crime problems; conducting geographical crime surveys; and developing the most efficient investigative plan to address health care problems on a national basis.

Agents and State and local investigators nationwide now network criminal activity crossing Federal jurisdictions and State lines. In 1989, a joint investigation of the New York Office of the Inspector General of the HHS, allegations of durable medical equipment dealers paying kickbacks to New York physicians and, in return billing Medicare for the equipment that was investigated.

In November 1989, 22 doctors and 5 employees were arrested and three search warrants were executed in a scheme in which the doctors received kickbacks for prescribing oxygen equipment and nebulizers. New York State officials arrested 4 licensed physicians and 16 individuals masquerading as physicians on State charges.

The FBI has taken a broad approach to health care provider fraud cases. While it has been recognized that investigation of Medicaid and Medicare fraud should be an objective of the FBI's health care program, our investigations have repeatedly shown the same health care providers who defraud Medicare and Medicaid also defraud commercial insurance carriers.

By aggressively investigating allegations of providers who are engaged in commercial health care fraud, we also discover and address Medicaid and Medicare fraud. We hope this approach will lessen the significant financial ramifications of health care fraud on the commercial insurance industry and also reduce the crossover fraud committed by providers against government-funded programs.

Our approach has resulted in the development of a number of successful and several significant investigations and criminal prosecutions, as demonstrated in the convictions by the Detroit FBI Office.

The FBI has developed close working relationships with private health care insurors and the corporate health care executives. The private sector has helped us understand the health care fraud trends. This expansion of FBI's intelligence base has helped to efficiently focus investigative resources at frauds involving both government-funded programs and private insurors.

In many instances, the FBI is able to tie together very complex fraud schemes crossing not only State lines, but extending to a myriad of private insurors convicted by a similar fraud activity.

To add to the arsenal of the investigative techniques, during April of this year, 1991, the FBI White Collar Section and other units at FBI headquarters sponsored asset forfeiture training of approximately 120 FBI field agents and agents assigned to the HHS, Medicaid investigators and Assistant U.S. Attorneys who actively work health care fraud matters.

The training focused on asset forfeiture in health care fraud investigations. Since April 1991, the White Collar Crimes Section has sponsored three additional health care conferences where emphasis has been placed on health care fraud forfeitures.

In two recent cases, this strategy has resulted in significant asset forfeitures. The first case involves a durable medical equipment fraud, in which a forfeiture exceeded $5 million and could ultimately total $18 million.

The second case, a Medicaid fraud scheme, agents seized diverted prescription drugs with a value of approximately $1 million and confiscated approximately $500,000 in cash. I would like to discuss that particular case in a little more detail in a few minutes.

During the last fiscal year, the FBI conducted 989 health care fraud investigations. Almost 60 agents are currently investigating 366 various health care fraud investigations.

In fiscal year 1993 budget process, the FBI is requesting additional agents and support positions to investigate health care fraud. Mr. Chairman, the FBI recognizes investigations involving health care fraud as a priority, and is aggressively investigating the most significant of these problems through the FBI's White Collar Crimes Programs, which is, by the way, the largest of the investigative programs in the FBI.

I would be glad to respond to questions, and I also have some exhibits that I would like to share with you.

Mr. DINGELL. Very well. I believe that that would be appropriate. If you would like to show the exhibits, we would be delighted to see them, or if you would like to start with the questions, we would be delighted to do that. The choice is yours.

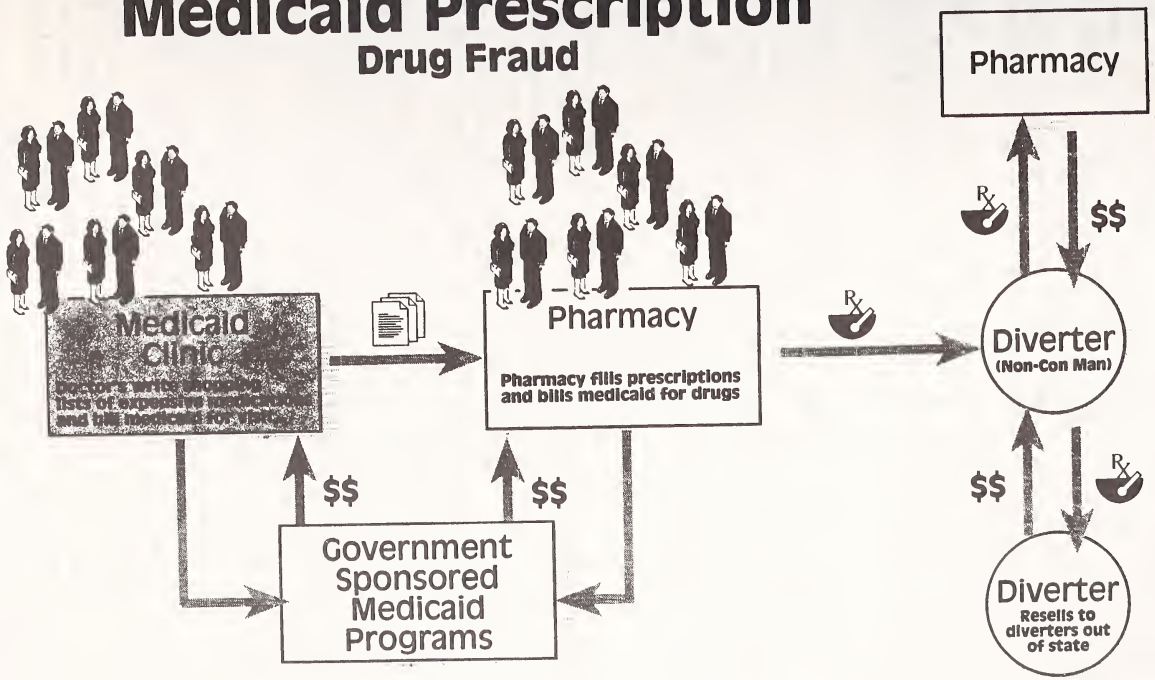
Mr. ESPOSITO. I think I would like to start with the exhibits.

Mr. DINGELL. Very well, then, I think that will be very useful.

Mr. ESPOSITO. This first chart, kind of a—is a myriad of what we heard on the TV earlier this morning. This is one particular scam that we are aware of that CBS News reported in New York, and moved to Baltimore, Md, but we know that this scam is taking place in several, if not all, the large cities in the United States.

[The chart follows:]

Medicaid Prescription
Drug Fraud



Mr. ESPOSITO. Starts out with the Medicaid clinic. You can see all the people, like it said on TV this morning, they are lined up outside waiting to get in. As the doors open, they go in, the doctor writes the prescription. The doctor then makes his money through Medicaid funds program, and he gets his profit.

The people that receive the prescription then go on to a pharmacy, get the prescription filled, and then the pharmacist makes his money through Medicaid.

The individuals, once they come out of the pharmacy, they then meet, which was referred on the TV as the non-C man, which is non-control man, goes to the diverter. The diverter pays them off at very little amount of money on the dollar, 10 cents on the dollar usually.

He then sells these drugs back to either that pharmacy or another pharmacy, and oftentimes sells them to other diverters. What we are seeing in our investigations is that these other diverters they are selling to are usually out of State, which brings up one of the problems we are facing in these investigations.

One of the charges—what we are trying to do in the FBI is use a myriad of violations of Federal law, not only health care statutes, but as I alluded to in the opening statement, the money laundering statute, fraud by wire, and also mail fraud.

In the mail fraud statute, when these diverters ship drugs to other States, they are using private carriers. They know not to use the mail, so we cannot charge them with mail fraud. That is a problem that is in the mail fraud statute that we are working with the Department of Justice on that, to get that changed.

But as you can see, everybody, as they alluded to on the TV show, everybody is making money here. What we are seeing in some other cases, we are seeing drugs being diverted overseas.

In one particular case that we have we are seeing that drugs are being sent from overseas, sent to the pharmacies. Now, these drugs are being relabeled. They haven't been checked by FDA. We don't know anything about them, and they are being sold to people in the community where the pharmacy is.

In other areas, we know that grocery stores are receiving these drugs. The grocer is not even a pharmacist, and he is dispensing them. So, the scheme is quite pervasive, and this is one example of a scheme. And to show you how lucrative this scheme is, we have some other pictures that I would like to show you now.

While he is getting ready to show the pictures, our investigations a few years ago in the FBI focused on different segments. For example, we would work a pharmacy or we would work a clinic. What we are trying to do now, and that is why you see less cases that we have, but the case involved the whole scheme.

So, instead of having separate cases, we would have one case on the whole scheme. Last summer, July, we had issued search warrants and conducted a search of an individual, and this is a pending case, so I can't go into specifics, but this person, we will call him a diverter. He falls into this area.

We issued a search warrant and the result being in this one apartment, we recovered $1.5 million worth of pharmaceuticals, and $500,000 cash. Actually, it was $497,000 in cash. And you can see it is all in $50's and $100's—$20's, $50's and $100's.

These other pictures, you will see, is the result of this search. What this diverter was doing was he was getting the pills and putting them in plastic bins. This bin, these pills you see here, that is $40,000 worth of AZT, which is the AIDS medicine. That is a hot pill on the market. It sells for $2.50 or $3, and they are getting like 20 cents for them.

But you can see by the way these pictures are set up, that the way these drugs are stored, I don't know if you would want to buy drugs this way.

This particular picture here shows that this diverter was actually relabeling the drugs, using lighter fluid to take off the labels, and relabel them. Because some of these drugs had expired their life expectancy, but were being sold.

During the same search, we searched one of these self-storage sheds, which this individual also kept some of his drugs in it. And you can see, the condition in which these drugs are stored now, when we went into this storage shed, the temperature that day outside was 98 degrees. Inside this shed, it was 130 degrees. And these are where these pills were being stored for resale back to the market.

In this picture, it shows also that the diverter was receiving these pills in large volumes, which means he was not—which shows there is another circle to this scam. Because this particular diverter must have been dealing with either a pharmaceutical company or a pharmacist, because you don't go into a drug store and buy drugs in that much bulk.

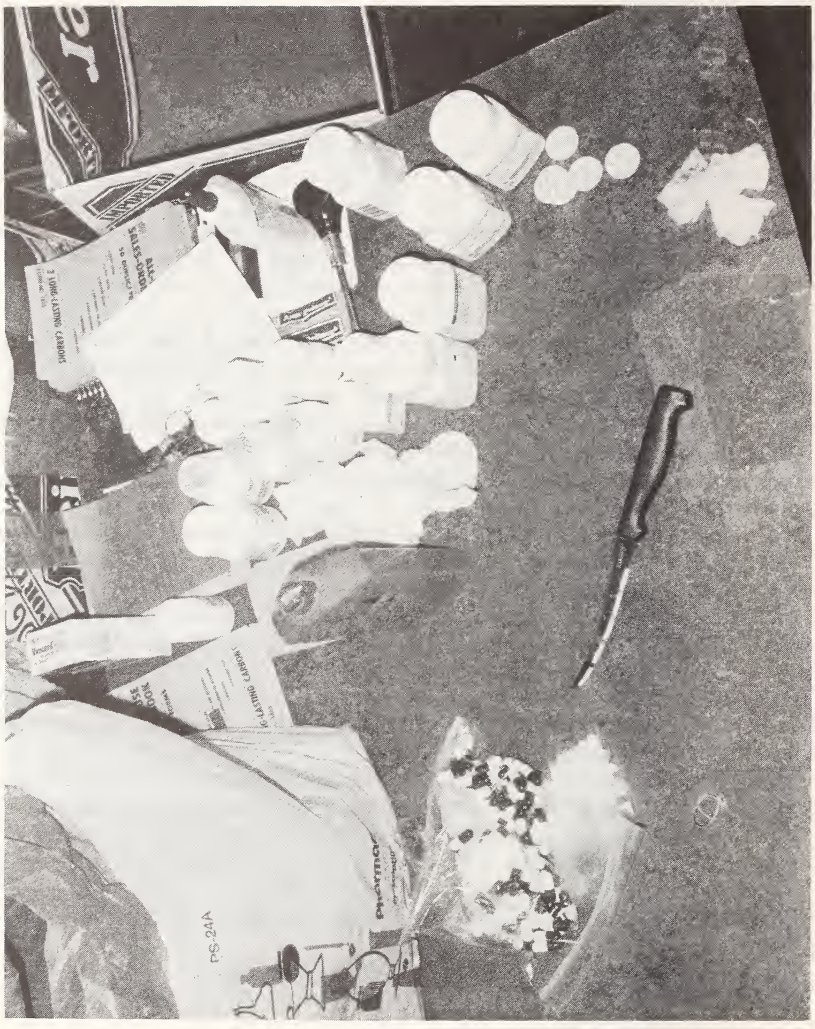
Also, this particular part of the picture indicates to us right here that this is a sample, which means a pharmaceutical representative must be involved.

So, these are some of the things we are coming up with, and that is the reason I wanted to explain that one particular scheme, because I think it is significant, and I think the amount of money that we have seized shows that this is not a penny-ante operation.

This one diverter who we are working with has indicated that he was dealing with 20 other diverters of the same or similar size, or greater size.

I will be glad to answer any questions you have.

[The photographs referred to follow:]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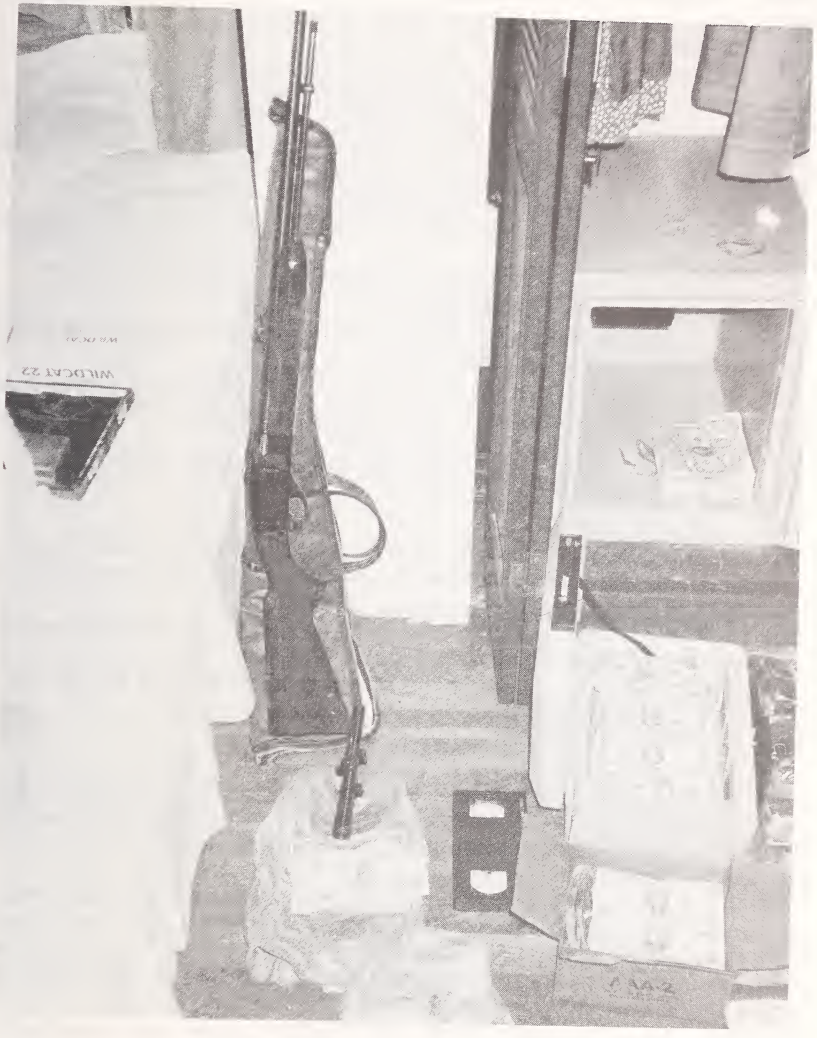
WILDCAT 22

Mr. DINGELL. Very impressive story, Mr. Esposito, but not a happy one.

Mr. ESPOSITO. No, it isn't.

Mr. DINGELL. Would you want to direct your attention to the recent case closed by the FBI involving a joint investigation of the Office of the Inspector General of HHS, and the FBI with regard to excessive billing for ambulance services, and could you describe that case for us in somewhat greater detail?

Mr. ESPOSITO. I will call on Mr. Ford.

Mr. FORD. Mr. Chairman, what office was this case investigated that doesn't——

Mr. DINGELL. It was the Office of Inspector General.

Mr. FORD. Our New York office.

Mr. DINGELL. At HHS and they worked with you folks at the FBI on that matter, as I understand it.

Mr. FORD. I believe that was a New York investigation, and that involved the physicians that were arrested; is that the investigation you are talking about; is that right?

Mr. DINGELL. It was ambulance services that were excessive.

Mr. FORD. In New York.

Mr. DINGELL. Yes.

Mr. FORD. That involved ambulance services which were paying kickbacks and receiving kickbacks involving the transportation of patients throughout the City of New York.

Mr. DINGELL. How much money was involved, how many people were involved, and what did they do?

Mr. FORD. We don't have those specifics details, but we can provide them to the committee.

Mr. DINGELL. Would you do that for us?

Mr. FORD. Yes, sir.

Mr. DINGELL. You also had another case, of which the Chair has been informed, involving diversion of funds, of all things, by a Blue Cross-Blue Shield claims examiner in Medicare. Could you describe that case in detail?

Mr. FORD. Was this also a New York case involving—that was a joint investigation which we had with the HHS IG. It was also a New York investigation. Payments were generated by one of the Medicare or Blue Cross examiners, and they were generated to third parties.

The fraud scheme lasted from about 1981 to 1985, and resulted in a loss of about approximately $900,000 to Medicare. The investigation resulted in convictions of three subjects; two of the subjects were sentenced to prison and ordered to make restitution to the government.

We could provide more detail on that at a later date.

Mr. DINGELL. If you would, for us, please.

Now, I believe, gentlemen, that you also mentioned to the staff of the subcommittee a potential billion-dollar fraud case in Los Angeles which involved two brothers who operated mobile medical units that were over-utilizing of diagnostic tests, misdiagnosing of ailments, not rendering services which were billed to Medicare, and paying kickbacks.

What could you tell us about that?

Mr. FORD. Mr. Chairman, that investigation was originally initiated by our Los Angeles Field Office back in about the mid-1980's. It involved two Russian brothers who were involved in rolling medical labs, basically.

They were taking labs throughout the Los Angeles County and Southern California area, and advertising free diagnostic screening and tests for patients in the area. In that investigation that resulted in an indictment of them, there were the Smushkevich brothers, two Russian immigrants, both were convicted and received 3-year prison—jail terms; two of the subjects in that investigation were acquitted in jury trials.

That was the old investigation. There was a second investigation that was later initiated by Postal Inspectors, Defense Investigative Service agents, and a group of other law enforcement agents out on the West Coast, in which a Federal grand jury issued an indictment in June of 1991 of the brothers.

Mr. DINGELL. Same brothers?

Mr. FORD. Same two brothers, yes. And it is a pending matter.

Mr. DINGELL. I don't want to know about pending matters.

Mr. FORD. We can't say anything about that.

Mr. ESPOSITO. Prior to that case, the claim was close to $1 billion.

Mr. DINGELL. Close to $1 billion. This is in the first or the second?

Mr. ESPOSITO. Second.

Mr. DINGELL. Apparently, they learned very little from the first, or maybe they learned a great deal?

Mr. ESPOSITO. Yes.

Mr. FORD. One of the issues that came up in that investigation was that not only were the—was the government defrauded and the State insurance firms, but a number of private insurance carriers. And as a result of the inability of those carriers to communicate with one another during the time that fraud was ongoing, it carried on for a long period of time.

Mr. DINGELL. The committee, as you know, has been very concerned about additional enforcement tools needed. For example, additional laws, additional powers to assess civil penalties, additional powers to inquire into the books or to require production of books and records, or the ability to make books and records open to investigation or inspection at reasonable times and places, or other enhanced penalties.

What can you tell us would assist you and would assist the Federal Government in detailing and prosecuting cases of these kinds.

Mr. ESPOSITO. Well, I have already mentioned change in the mail fraud statute, but it would appear to me that right now, there is not an entity that all the information comes to, one central point.

What I would like to see, if I had a dream wish, would be a criminal referral form similar to what we are using in the financial institution fraud area, where no matter where the fraud is perpetrated, whether it is in—whether it comes to HHS' attention, State Medicare, Medicaid, a private insurance carrier, whoever, that they would have to fill a form out and send it to one central place, in this case the FBI, who then can determine once and for all what is the fraud, where is it being committed, what types of frauds are going on, and who is addressing it.

And we put out a report similar to what the Bureau puts out every year, uniform crime reporting, so we get a better handle on this program. Also, I would like to see in any statutes that are passed or any legislation forfeiture provisions, because in the example I gave, the $500,000 or $497,000, that is being forfeited back to the government. So, the government can replenish the fund.

Mr. DINGELL. Is there now a forfeiture provision in the law with regard to cases of this kind?

Mr. ESPOSITO. No.

Mr. DINGELL. There is not?

Mr. ESPOSITO. There is not.

Mr. DINGELL. So you think forfeiture would be a useful tool?

Mr. ESPOSITO. Forfeiture, there is a provision if you charge title XXI of the Comprehensive Drug Act. Also, if it is a steroid, there is some forfeiture provision.

Mr. DINGELL. Have you had any referrals from the Health Care Financing Administration for criminal investigation or prosecution of laboratories found to be committing fraud under the Criminal Laboratory Improvement Amendment since 1988?

Mr. ESPOSITO. No, we have not.

Mr. DINGELL. You have not.

Gentlemen, you have been here a long time. I want to express my thanks and thanks from the committee to you for your assistance. It would be much appreciated if you would continue to assist the staff and guide us and advise us with regard to possible legislation changes in the basic statutes under which we all work.

Mr. ESPOSITO. Thank you.

Mr. DINGELL. You have our thanks. We appreciated your presence here, and we also appreciate your patience.

The committee will stand adjourned until the call of the Chair.

[Whereupon, at 2:30 p.m., the subcommittee adjourned, to reconvene at the call of the Chair.]

HEALTH CARE FRAUD AND WASTE

THURSDAY, OCTOBER 17, 1991

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Oversight and Investigations,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. John D. Dingell (chairman) presiding.

Mr. Dingell. The subcommittee will come to order.

Today, the subcommittee continues its hearings on a matter of great concern, both substantively and jurisdictionally to the full Committee on Energy and Commerce, to this subcommittee, to its members, and to the Chair—health care, the inadequacy of it, the excessive cost, the unfairness of it, the mal-distribution of benefits, and a generally outrageous situation in the interest of no one and certainly not in the interest of the country.

We will focus today as a part of our concerns in this area on what might turn out to be significant events associated with fraud, waste, and abuse in the health care industry. In August, ABC's Prime Time Live, with the help of Citizen Action, aired two segments on some very outrageous patient charges for selected medical supplies at Humana's Suburban hospital in Louisville, Ky.

Since those segments ran, the subcommittee has been inundated with letters from across the country from patients who believed that they have been ripped off when they saw the charges on their hospital bills.

In the case of Humana, the subcommittee has seen an example of a crutch that cost Humana $8.05, for which they charged the patient $103.65. This is not, however, the whole story.

If the patient wanted a rubber armpit pad that went with the Humana crutch, this 90 cent item cost the patient $23.75. Again, this is not the whole story. If the patient wanted a rubber tip for the Humana crutch, this 71 cent item cost the patient $15.95. Therefore, this simple crutch that costs about $15 at the local drug store, but costs Humana only $9.66, costs the Humana patient $143.35. In addition, some other examples might be useful. At Humana, a bag of ice that costs 99 cents at the local Seven-Eleven costs $32, a Vaseline dressing pad costing $1.03 is charged to the patient at $25.39, and a disposable slipper costing 85 cents is billed to the patient at $23.72. The now-famous $640 toilet seat pales in the face of some of these Humana charges.

Why are these prices being charged by Humana? Why do the insurance companies and the government, who pay most of the bills,

find these charges acceptable? Medicare and Medicaid are major payers, but so also is Blue Cross and Blue Shield and a number of insurance companies. All of these should have significant concerns as to how these costs are billed to them. There are claims that the hospital pricing system is complex, and probably too complex for the Congress to fully understand. That may, in fact, be so, but it is the intention of the subcommittee to persevere and to get to the bottom of this matter.

In fact, we have learned a few basics as of this time. To determine whether the price list from Humana Suburban Hospital in Louisville was an aberration within the Humana system, the subcommittee requested price lists from all 82 Humana hospitals; we received price lists from 77 hospitals. The subcommittee learned that the price lists from across the country exhibited the same level of, quite frankly, outrageous charges, but the outrageous varied from item to item and hospital to hospital.

Suburban, in Louisville, it can be said, is not unique. What we have learned from others in the industry is that Humana is not unique.

What is going on here? In the 1970's hospital room rates accounted for about 80 percent of hospital cost. As the government, private insurers, and the media focused on rising hospital costs, they generally focused on room rates as the measure of competitiveness and cost control.

However, the hospitals then pulled a not-so-subtle switch. Room rates were kept down and other charges, known as ancillaries or supplies and medications, started to balloon in price, like the crutch, the aspirin, the diapers, and the saline solution. At the end of a hospital stay, the patient is hit with pages and pages of charges for a bewildering number of ancillary services that he or she cannot even remember receiving in most cases.

Consumers may ask a Humana about their room rates prior to choosing a hospital. But what can the consumer ask a hospital about charges on cotton swabs, ice, crutches, crutch tips, needles and other things?

Hospitals apparently know this and apparently exploit it to the fullest extent. One of the things the committee wants to do is to find out how this shift in the basic structure of hospital billing is affecting not only the consumer but also the Government and nongovernment plans for the payment of services rendered by hospitals.

When asked, hospitals concede that there are serious problems in pricing and reimbursement in the industry and cite the need to cross subsidize. Perhaps there is a need to cross subsidize, perhaps there is not. Perhaps the cross subsidy is indeed caused by government practices. Perhaps cross subsidy, however, is tied into other billing structures and other charges in the billing structures which tend to maximize the benefits of hospitals.

Whatever the merits of the mea culpas and explanations that the subcommittee and others are hearing, one thing is clear, this is a complicated system. It needs to be reviewed, and we need to find out whether it has to be reformed and where it has to be reformed. Appearances are that there need to be reforms starting at the ground and going to the topmost elements of the structure.

This subcommittee has spent a good deal of time on the acquisition of major weapons systems. At one time the subcommittee, as all will recall, examined the over-pricing of a military transport aircraft, the C-5B. Both Lockheed and the Air Force told the subcommittee the pricing of a state of the art aircraft like the C-5B was too complex for the Congress to understand.

However, with the help of selected public-spirited officials in the Air Force, we determined that there was a "should cost" for the C-5B aircraft, and we then identified what that "should cost" was. Taxpayers saved from that event a half-a-billion dollars through a renegotiated production contract.

With the help of these same people and others who have a proper sense of public spirit and the same techniques as well as the General Accounting Office and the Inspector General of HHS, we will proceed to move through the same process, and we believe that we will be able to determine what hospital services, quote, "should cost", close quote, at Humana and at other hospitals and find whether there is fat here, whether there is fraud, waste and abuse, and whether or not and how that fat should be removed.

This hearing should begin the process of overdue change. We will look at possible gaming of the system and try and find out whether such goes on and, if so, where. We will try and prevent the misleading of consumers, the misleading of insurance companies, the misleading of government agencies.

We will also try and deal with the possible misleading of industrial, business, and corporate America that is paying a very large part of the costs of these programs and the possible abuses into which the subcommittee intends to inquire.

We look forward to the testimony of all of our witnesses here today, and the Chair recognizes my good friend from Virginia, Mr. Bliley, for such comments as he chooses to make.

Mr. BLILEY. Thank you, Mr. Chairman.

Today the subcommittee considers billing practices used in the hospital industry. The costs of health care have been rising rapidly in the past few years. This dramatic rise in the cost of health care concerns the Federal and State governments, because it drives up the cost of the Medicare and Medicaid programs.

It also concerns private industry, which finds itself paying more and more for less and less health care for its employees.

The cost of hospitalization is a major component of the cost of health care. Twenty years ago, the charges for a hospital room covered around 80 percent of the total amount of charges that typical patients found on their bills. Today, by contrast, the room charge covers only around 15 percent of all the charges on the bill.

Instead of a room charge, the patient finds the bill contains numerous charges for ancillary items, which can range from hypodermic needles, to bed pans, to artificial hips.

If hospitals were only itemizing their bills thoroughly, this practice would probably not be an unwelcome development. But information furnished to the subcommittee staff in the case of Humana hospitals shows that the markups over the costs of acquisition of these ancillary items have been little short of fantastic—900 percent markups are not uncommon.

When confronted with the magnitude of the markups, Humana's response has not been to try and justify the markup as a reasonable cost of providing the ancillary item to the patient. Rather, Humana has simply asserted that it is doing what every other hospital is doing. For most people, the excuse that everyone else does it ceased to be acceptable in junior high school, but Humana does have a point. Other hospitals do engage in exactly the same billing practices, designed apparently to maximize revenues based on the payer mix of the particular hospital.

If such markups took place as a part of arm's length commercial transactions in which the government played only a small role, perhaps they would be unworthy of congressional investigation. But hospital charges are anything but arm's length transactions, and the government's role in paying them is anything but small.

I commend you, Mr. Chairman, for holding this hearing to better inform the subcommittee and ultimately the Congress of just what we are buying with our health care dollars. There are a number of important questions that need to be answered.

Why have hospitals shifted charges from room rates to ancillary items? Have hospitals used low room rates as loss leaders to encourage patients to enter, only to hit them with excessive charges for ancillary items once they are in the hospital and their freedom of choice constrained? If hospitals are free to markup ancillary items to meet revenue goals, is any cost containment effort on the part of the government or of private payers likely to succeed?

These questions, and other similar questions, need answering, and I again commend you, Mr. Chairman, for beginning this investigation. I look forward to hearing from our witnesses today.

Thank you, Mr. Chairman.

I yield back the balance of my time.

Mr. DINGELL. The time of the gentleman has expired. The Chair recognizes the gentleman from Oregon, Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman. I want to commend you, Mr. Chairman, for what I think is a very important inquiry.

The markups in medical supplies found by this subcommittee are grotesquely inflated and outlandish, and the eye patch or the aspirin that costs a buck at the neighborhood drugstore and maybe 25 times that at the hospital is going to be a metaphor for our private system of paying for health care that is now in a shambles.

The private system is a bizarre hodge-podge of cross subsidies, deep discounts for some lucky buyers of health care, and a no-limit to over-charging system of billing the others.

Mr. Chairman, and colleagues, the evidence that we have today certainly adds new ammunition to the cause of those who want a single payer health system. You just look at this mess and you just look at the evidence, and you say we ought to jump the status quo and go forward with a single payer. But, Mr. Chairman, and colleagues, I would submit that there is another approach that can be taken right now to address these rip-offs without the added cost of the single payer system, and that approach would build on efforts that have already been taken in this subcommittee to begin the task of getting tough with those who are paying these bills, the private insurance companies. Let's make no mistake about it.

The heart of the problem here is that the private insurance companies are paying these inflated costs. They are just operating like cash registers where, in effect, the outlandish claim is submitted, it is paid without aggressive scrutiny, and the costs just get passed on. Now, we all know that some private insurance companies have begun to get tough in terms of scrubbing their billings, but for the most part, the way it is done in the private insurance industry is to go along, get along, and just have everyone think that medical costs are going to go up naturally.

If we are going to take the incentives out of billing in this wasteful, extravagant fashion, the private insurance companies are going to have to get tough and perform the task of being hard-nosed about billing.

I am not just talking about being hard-nosed about a particular aspirin or an eye patch or a pill. The private insurance companies are going to have to be tough in negotiating a whole package so that you can't just shift costs from one item to another.

Managed care has begun to move us in that direction, but we have only taken the baby steps.

The last point that I would mention, Mr. Chairman, is we have to remember that if we go at this item by item, what can happen is you will lower the cost for a particular medical supply such as an aspirin or an eye patch, but utilization will then go up, and the citizens will still be out just as much in the pocket, so the billing practices that we are looking at today, in my view, are systematic of a great deal more of just plain waste. They are systematic of a private system of paying for health care in this country that is in a shambles, and for those of us who have reservations about the Government simply taking over health care altogether, we have got to get the private insurance companies to stop paying these bills and start being responsible about the way health care is funded.

I yield back the balance of my time.

Mr. DINGELL. The Chair thanks the gentleman.

The gentleman from New York.

Mr. LENT. I have no opening statement, Mr. Chairman, but merely want to commend you and the ranking minority member for holding this hearing.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair looks forward to working with him as we go forward on this matter.

The gentleman from Georgia.

Mr. ROWLAND. Thank you very much, Mr. Chairman.

Mr. Chairman, one of the things that I hear often about in town meetings that I have in my district and from people who write me and call me here in Washington is the high cost of health care. It is particularly on the minds of our senior citizens and those people who, for whatever reason, are sick. Most people are not sick, and consequently, they don't focus much attention on this problem, but those people that feel a threat to their health do focus a lot of attention on this problem, and I want to say, Mr. Chairman, that the high cost of health care poses not only a threat to our health care delivery system, but also poses a threat to the health of individuals because those people who are uninsured or those people who do not have the money to pay for their medical care will delay getting

that care until they become much sicker, and in instances actually will die because they do not get the care that is needed because of the high cost of that care.

So this hearing focuses not only on the delivery system but on the health of individuals as well. Are these tremendously high markups in supplies justified?

I would be interested to find out, Mr. Chairman, just what will be uncovered in these hearings, and I want to commend you for having focused on this particular issue because I believe it does pose a threat to our health care delivery system in the country and the health of individuals, as well.

Yield back.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair announces that our first panel is a panel composed of members of the staff of both the subcommittee and the minority.

The Chair wants it known that we have a special appreciation to our staff for the good work they do, and that again covers both the membership of the staff of the subcommittee and the minority staff. The panel members today will be Mr. Bruce Chafin, Mr. Dennis Wilson, and Mr. F. James Shafer. Gentlemen, we thank you for your presence and we welcome you to the subcommittee. The Chair is sure that you all understand the way that this subcommittee functions, that it is required that all witnesses testify under oath, and the Chair asks you then, do any of you have any objection to testifying under oath?

Mr. WILSON. No, Mr. Chairman.

Mr. CHAFIN. No, Mr. Chairman.

Mr. DINGELL. The Chair informs you that the rules of the subcommittee and the committee and the rules of the House are there to inform you of your rights and the limitations on the powers of the committee. The Chair also advises that you are entitled to be represented and advised by counsel in your appearance here today.

The Chair asks do any of you desire to be advised by counsel as you testify before us today?

Mr. WILSON. No, Mr. Chairman.

Mr. CHAFIN. No.

Mr. SHAFER. No.

Mr. DINGELL. Gentlemen, if you have no objection to testifying under oath, if you will each please rise and raise your right hand.

[Witnesses sworn.]

Mr. DINGELL. You may each consider yourselves under oath.

If you please, the Chair will recognize you for such statements as you choose to give us in any order of appearance that you choose.

TESTIMONY OF BRUCE F. CHAFIN, SPECIAL ASSISTANT, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, ACCOMPANIED BY F. JAMES SHAFER, SPECIAL ASSISTANT, AND DENNIS B. WILSON, MINORITY COUNSEL

Mr. CHAFIN. Mr. Chairman, and members of the subcommittee, we appreciate this opportunity to be here today to discuss our findings regarding charging practices at Humana Hospital.

Several months ago, the subcommittee received detailed information for more than 1,500 items that Humana Suburban Hospital in

Louisville Ky, was providing their patients. Included in that data were the prices Humana actually paid for the items versus the prices they charged their patients. You directed the staff to conduct an analysis of the Suburban markup practices, as well as to obtain similar data regarding the other Humana hospitals.

We were able to obtain data on 77 out of the 82 hospitals in the Humana system.

Beginning with Humana Suburban, we found that over 55 percent of these supplies were marked up at least 5 times their cost and that more than 17 percent of these items were marked up 10 times their cost.

Examples of these markups included adult crutches, where Humana paid $8.05 but charged their patients $103.65; air diffusers where Humana paid $8.28, and charged their patient $332.90; an eye patch that Humana paid 90 cents for while the patient charge was $25.70; irrigational saline solution, 1,000 milliliters, Humana's cost, 81 cents, patient charge, $44.90.

In addition, we received similar data from Humana on 76 other hospitals in their system. The analysis of the other Humana hospitals indicates that Suburban is very typical of Humana's markup practices and, in fact, Suburban ranks 46th out of the 77 hospitals in terms of the percentage of items marked up 15 times or more.

Overall, Humana hospitals priced 44 percent of these items 5 times their cost, 18 percent of their items 10 times their cost, and more than 10 percent of the items 15 times their cost.

At the top of the Humana hospitals markup list were San Leandro, Huntington Beach, West Anaheim, and Westminster, Calif.; and Biscayne, Fla.; and Mountain View, Colo. hospitals. All of these hospitals priced at least 80 percent of their items 5 times their cost or more, with San Leandro leading the list with 91.1 percent of their items marked up at least five time their cost, 67.5 percent 10 times their cost, and 49 percent 15 times their cost.

Examples of items at San Leandro include an 18×24 inch heating pad. Humana paid $5.74 and charged their patients $118; a 3¼ inch fingertip splint, Humana paid 25 cents, the patient paid $33; a traction thigh sling, Humana's cost, $38.25, patient charge $278.50; esophagus tube, Humana cost, $151.98, patient charge, $1,205.50; mammary bra, Humana cost, $46.80, patient charge, $455; bile bag, Humana cost, $5.50, patient charge, $64.

In total, there are tens of thousands of ancillary or supply items that a hospital may provide. These types of items vary from hospital to hospital within Humana.

For example, Humana's hospital in Alaska has a high of 4,560 inventory items, while Humana's Pembroke Pines hospital in Florida has a low of 271 items.

As a result, the mix of items varies from hospital to hospital, making difficult direct hospital to hospital comparisons. However, we did review several items across the hospitals for comparative purposes.

For example, Humana's cost for a wrist splint was $4.60 at a number of hospitals. However, their patient charges varied. It was $79.20 for the $4.60 item at Audubon in Louisville, Ky., $101 for the $4.60 item in Alaska, and $125.10 for the same $4.60 item in Russellville, Ala.

Similarly, the cost of an egg crate was $3.20 while the patient was charged $30.20 at Huntsville, $46.95 at Russellville, $60.83 at Florence, and $70 at San Leandro. An egg crate, by the way, is simply a sheet of foam bubble wrap for the patients to lay on to help avoid bed sores.

Our analysis indicates that there seems to be no corporate pattern to the markup of individual items. Instead, there was an overall corporate pattern of high markups within the ancillary or supply items hospital by hospital.

The overall trend was clear. While prices may vary item by item among the hospitals, hospital administrators followed a consistent pattern of making supply and ancillary items big profit items. The obvious question is why. Why are the hospitals marking up some items 5 times, 10 times, and 15 times their cost. For some insight to that, I will refer to Dennis Wilson, minority counsel.

STATEMENT OF DENNIS B. WILSON

Mr. WILSON. Thank you.

Twenty years ago, hospital room rates represented about 80 percent of a patient's charge. As part of the cost containment strategy, Medicare, Blue Cross/Blue Shield, and other third party payers focused on these room rate charges with the thinking that if they controlled the cost of 80 percent of a given hospital stay, they would, in effect, win the war against hospital cost growth.

Over time, that semi-private room rate became the yardstick to measure the costs associated with that hospital. Hospital administrators, recognizing this focus, began to hold the increase in room rates artificially low and shifted their sources of revenue into a variety of other areas.

Today, the ratio that existed 20 years ago is now completely reversed, with room rates representing 15-to-20 percent of hospital revenues and the remaining 80-to-85 percent being generated in other areas.

In effect, the room rate and other high profile items and services became loss leaders for the hospital's customers and payers, while at the same time, hospitals shifted the charges away from the room and into ancillary services and supplies.

Representatives of the American Hospital Association told the subcommittee staff that hospitals all across the country are artificially holding down room rates so that when reporters, cost conscious consumers, and others call, they will be quoted the artificially low rates.

Typically the hospital then makes up the loss revenue with higher billings in supplies.

This phenomenon has several outcomes. Reports on health care costs that use anything less than complete patient bills will be understated because the measures being used are artificially deflated. Patients, who are increasingly being asked to pay more of the bills, will be attracted to the hospital with a lower room rate and then be fleeced with unanticipated high, hidden charges—hidden until you get the bill—such as $84.94 for a bag of saline solution, $150 for a crutch, $13.35 for a diaper, $16.65 for a bag of ice, and $4.55 for a toothbrush.

To the extent consumers are cost conscious and make their decisions based on price, the practice of high markups for ancillary items thwarts their effort. The beauty of this system for the hospital is that many potential patients who attempt to shop around and compare prices will make their decision on the more obvious items such as room rates, MRI charges, x-rays, and lab charges.

Then, only after the decision is made and, in fact, usually when the patient is being discharged, or even later, will the patient see the unreasonably high prices for these ancillary items.

Mr. Chairman, since we have commenced this investigation, we have received numerous calls from patients of Humana and other hospitals who were shocked and felt victimized when they received their final bills and saw how they had been billed for these ancillary services.

However, they felt there was little they could do because the services or items had been provided and used.

Representatives of Humana have freely acknowledged this practice and have stated that these patient charges are not cost based. In fact, because of a lack of specificity in their accounting system, they are unaware of the full cost of providing these items.

They acknowledge their hospital administrators are increasingly using ancillary and other charges to offset artificially low room rates.

They refer to this phenomenon as cross subsidization.

Humana argues that this cross subsidization does not generate another dime in revenue for the hospital. It just changes the source of that revenue. We may want to have the General Accounting Office perform a cost impact analysis of such cross subsidization practices at Humana.

What is clear is that this practice leads to very misleading cost and pricing data being provided to the public concerning hospital charges. Patients who are attempting to shop around are being quoted artificially low prices to entice them into the hospital or perhaps into a particular hospital, only to find exorbitant prices being charged for the everyday-but-necessary items.

Insurance companies or other third party payers who have focused their negotiations on high profile items as a measure of hospital's cost effectiveness are being misled and thwarted. Further, it paints a distorted picture of the rising hospital costs over time because the public and media continue to focus on highly visible items, such as room rates, that are being subsidized and do not realize that they are being gamed on the ancillary or supply items.

Mr. Chairman, it is as if the industry is responding to efforts to contain costs like a balloon responds to pressure when you step on it. When you contain it or force it at one spot, it just pops out somewhere else, but the overall volume of the balloon or, in this case, the revenues of the hospital, remain the same.

We are continuing our discussions with representatives of the hospital industry, with insurers, and with HCFA officials. It is obvious that the system for paying hospital bills is both complex and changing. Many third party payers are negotiating discounts with hospitals, leaving other payers such as persons without insurance or persons with high deductibles on their insurance paying ever-higher bills as hospitals raise charges to meet their revenue goals.

We will continue to pursue the topic of hospital charging and billing.

We will do our best to respond to any questions that you may have.

Mr. DINGELL. Mr. Wilson, Mr. Chafin, and Mr. Shafer, the subcommittee thanks you.

Did you have any comments, Mr. Shafer?

Mr. SHAFER. Not at this time.

Mr. DINGELL. Gentlemen, the subcommittee thanks you for your assistance to us. The Chair will recognize members of the subcommittee for purposes of asking questions, commencing with the gentleman from Virginia.

Mr. BLILEY. Mr. Chafin, the Federal Government has been making efforts to contain the cost of health care, especially in its Medicare and Medicaid program. What are the implications for cost containment of the system of hospital billing that you have described?

Mr. CHAFIN. Basically, we are seeing that the charges have been disassociated from the cost, so what we are forced to deal with is rolled up, bottom line numbers in terms of here are the costs to the hospital, here are the revenues of the hospital, and we are forced to deal with it on a very aggregate basis. You may remember back in 1984, we got started on this with the defense contractors, and this subcommittee literally had to get in behind the cost pools and get down to the vouchers, if you will.

Recently we had to do that with the universities and institutions, such as Stanford. We see that ongoing now. We are now into EPA Superfund contractors similarly, we are into DOE on cleanup sites and operations of the nuclear weapons plants. We believe it is time that we are going to have to get in, start trying to understand where these costs are coming from, what they are associate with, and effectively look at whether they are allowable, whether they are reasonable, and if we are going to try to focus on cost containment, that is how it is going to have to be done. Billing it at other bottom line level is simply not working.

Mr. BLILEY. How would we go about it?

Mr. CHAFIN. We will go about it just like we started back in 1984 with the defense contractors. Somewhere, I don't know where, in the last 20 years, the Federal Government's approach to audit and cost containment went too high. We started dealing with allocations of cost pools and allocations of cost incurred and auditing based on historical costs and pricing based on historical costs. We stopped looking at how are those costs being generated, are they necessary, are they reasonable, and are they allowable. I think this subcommittee, honestly, is leading the revolution back towards looking at the actual costs, looking at the vouchers, and trying to figure out are they, in fact, necessary, and when we can get our handle on the costs and figure out where we can deal with that, I think you can see situations where, instead of negotiating with Stanford, whether, in fact, they need to go from a 74 percent rate to a 75 percent rate, when we get in behind the numbers and really do an audit, we find out that the rate is 55 percent. I think we have got the GAO energized and we have got HHS I.G. energized,

and that when we get in behind these numbers, maybe we can try to have an impact on cost.

Mr. BLILEY. Thank you.

Mr. Wilson, Humana says that looking at individual items is misleading because its overall markup is not excessive. Why should we be concerned about individual items being outrageously marked up if overall Humana's markups are within the realm of the reasonable?

Mr. WILSON. Well, I guess the question that you could pose to Humana is why within this average markup of 127 percent some items are being marked up much more, others much less, and others perhaps not at all or even being understated. Obviously, Humana has made a decision about why certain items should be marked up and certain items not marked up and certain items possibly even understated to reach the revenue goals that they have set for their hospitals.

Our analysis, coupled with that of GAO, suggests that this is by no means random or even arbitrary, that they have selected certain items that are high volume, low cost, and relatively inelastic demand and marked them up. These are also items that the consumer isn't likely to ask about when they make these type of—when they make their decisions about which hospitals to enter into.

So I think what Humana says is true yet leads to a certain bottom line, but why are they adjusting their charges to reach that bottom line?

Mr. BLILEY. Well, another argument that has been advanced by the hospital is that very few people pay, quote, retail, in the form of the very high markups on the ancillary items, and that their overall bills are not out of line.

How would you answer that?

Is that a valid argument?

Mr. WILSON. I guess it depends on your perspective. I am reminded of the story of the economist that was drowned in the river because the average depth was only 4 feet. If you are among the people that pay retail, the fact that somebody else may be paying less isn't materially reassuring, so if you are—and particularly when those people are among the most vulnerable.

For example, if you don't have insurance, nobody is out there negotiating a discount on your behalf. You pay full retail. If you don't have insurance, you are likely either to not have a job at all or to have a job that is sufficiently, I guess, underpaid, under market, you don't have an insurance plan.

You are among the people in the population least able to afford retail, and yet you are the one that is most likely to pay retail. That would be my answer.

Mr. BLILEY. Thank you very much, Mr. Chairman.

I see my time is up. Thank you.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair recognizes the gentleman from Oregon.

Mr. WYDEN. Thank you. Let me also commend the staff for an excellent job. I have one factual question.

I understand that at one of the Humana hospitals you found some additional evidence addressing this question of how Humana

may be keeping the price of high visibility items down and making money elsewhere. My understanding is that you have been able to look at some areas such as pharmacy practices and the like and gather some additional information.

Mr. Chafin, can you enlighten the subcommittee on that?

Mr. CHAFIN. Mr. Wyden, what you are referring to here is we believe that benchmark in this general trend is the idea, this cost shifting that is going on, it is going on within a patient. We will hear about cost shifts across patient mixes and that sort of thing, but we also need to focus—there is a cost shifting going on within the patient.

You are going to get a real cheap room rate, but then by the time you get finished paying for your sheets and your ice and the other items that you are going to be hit with in that room, you are going to have ended up paying a very high room rate—not room rate, total charge, but most of it is associated with the room, not with providing the ice.

We have seen that in a micro level at the Humana Hospital in New Orleans. The pharmacy markup, we have got a sheet that Humana gave us. We can submit it for the record that literally shows the markup practices in the pharmacy.

Right at the top of the list, high visibility items. What do we do with high visibility items? We mark them up, average wholesale price plus 10 cents. So what they consider a highly visible item that costs $10, they bill you $10.10. But you know what?

When it is not a high visibility item, and it is an injection, for example, that same $10 item is marked up $10, so it is going to be $20, and right here in their own criteria, the lowest markup, the one that barely gets any markup at all is what they call high visibility. Then when we come on down to all the other—the tablets and the liquids and the diagnostics, we have different markups, higher markups.

Mr. WYDEN. Now, does the company assert that the prices they charge are cost-based?

Mr. CHAFIN. No. In fact, they deny they are cost-based. They have just emphatically said you can't take the patient charges and go back to the price we pay. At the same time, however, they like to point out that what we are seeing here is the price they are paying for an item, but it is not including the delivery charge, if you will, to get it into the patient's room and that there are other costs here, but they can't quantify them, and they certainly don't assert that the difference between the prices that we are seeing in what they are paying versus the prices that they are charging the patients is at all——

Mr. WYDEN. It seems to me, the central point of what you are saying is that the company is disassociating the price of the item versus the cost of the item, and if that is the case, they are just basically throwing cost control out the window. Is that correct?

Mr. CHAFIN. I would agree. When you ask them or ask other hospitals or ask the hospital association why we are paying $150 for a crutch, they start to talk to you about the cost of the room, and that is exactly it.

They are justifying the high prices on these ancillary and supply items based on cost from different areas.

Mr. WYDEN. Let me ask you just one other question that I tried to touch on in my opening statement in effect as it relates to the insurance companies and the fact that they are basically ratifying these outrageous billing practices by paying the bills.

You all have essentially found that you have gotten thousands of different services in a hospital, thousands of different prices. Unless you have a system, a process of bundling these together so you have some leverage, it seems to me we are never going to have any real accountability over price.

Is that your assessment?

Mr. CHAFIN. You are talking about leverage from the payer?

Mr. WYDEN. Yes.

Mr. CHAFIN. Oh, absolutely. You can look at the discounts being offered, and I think you will find a very strong correlation to the payer with the most leverage gets the biggest discount, and that is exactly what is happening.

Some people are paying these charge, some people are getting 5 percent off of these charges, some people are getting 30 percent, 40 percent off these charges.

Mr. WYDEN. Let me ask you one other question.

I see the light is on. I don't want to use my time. Doesn't this have impact on government programs as well and that programs like Medicare have to pick up some of the freight for the kinds of problems you have exposed?

Mr. CHAFIN. Well, again, it goes back to the if you can't get a handle on costs, you can't contain costs. We are trying to find out, for example, in negotiations on DRG's where they are showing their aggregate costs, their aggregate revenues, and what kind of markup they are going to need.

There is really no basis for us to get in behind it, like we did at Stanford. Stanford came in, and they made very good arguments why if they didn't get to go from 74 percent to 78 percent, they were going to be penalized, and if we stayed at that level, I guess we would have had to agree. We went in way behind that level and came up with a totally different answer.

Mr. WILSON. Mr. Wyden, may I add one thing? In fact, when we talk to insurance company representatives, the first thing we have to get straight is how we are going to define our terms. We tend to use cost as what it is actually costing the hospital to acquire an item and to deliver it to the patient.

They tend to talk about charges as if those are costs, so when we first started talking to them, we almost had to define our terms because it was unclear as to who was talking about what and I think that Mr. Chafin's discussion of the kind of the aggregate is exactly on point on that, the notion that you go behind what the hospital is telling you, you actually look at what makes up the gross figures that they are telling you for the radiology department or whatever. I can't say it hasn't occurred to the insurance companies, but it does not seem like anything that I can tell they have aggressively pursued.

Mr. WYDEN. I share that view, and it is good to have another bipartisan inquiry where we are very much looking at these issues in the same way.

Thank you, Mr. Chairman.

Mr. DINGELL. The time of the gentleman has expired.

The gentleman from Georgia.

Mr. ROWLAND. Thank you, Mr. Chairman. I want to pursue that same thought that was raised by Mr. Wyden.

Do you know if there is a difference between the charges billed to Medicare by private insurance versus a cash payer?

Mr. CHAFIN. Under Medicare, you are going to be paying based on the DRG. Within the individual or private payer, you do have a single charging system. Everybody starts anyway with the same charge. What Mr. Wyden was talking about is that against those charges, many of the payers have negotiated discounts.

Usually, the bigger you are, the more business you get offered and the greater your leverage, the greater your discount.

Mr. ROWLAND. What about an individual who does not have insurance incurs charges?

Mr. CHAFIN. That individual, really the sort of low man on the totem pole and the one that everyone is most concerned about, is literally becoming the mule for these extra charges. That is the pretzel logic in all of this is that one individual out there that doesn't have insurance is paying it out of his pocket, doesn't have anybody negotiating discounts, he is going to pay the kinds of prices that we are seeing across the country, seeing not just in Humana.

Mr. ROWLAND. The individual that is more or less defenseless, I guess, you might say is the one that gets beat up on the most?

Mr. CHAFIN. Exactly.

Mr. WILSON. Mr. Rowland, one of the things, that defenseless individual, because he knows he is not insured, actually tries to shop around, tries to figure out what his costs are going to be, calls several hospitals and compares their room charges, he is in really bad condition because now he is being quoted misleading, essentially misleading information, so he gets it at both ends.

Mr. ROWLAND. An individual that shops around, of course, an individual admitted to the hospital by a physician, that is the way they get in. What goes on between the physician and the patient? Do you know? Does the physician tell the patient to shop around? What takes place there?

Mr. CHAFIN. Obviously, it is going to vary, depending on the relationship between the patient and his physician and, depending on whether the physician can operate at several hospitals. It depends on the physician. In addition to the number of patients that have called us, we have dealt with quite a number of physicians across the country who are extremely concerned about this because, generally speaking, their patients are not too happy with them when they get presented with these bills and see these kinds of charges, and we have had a few physicians "get off the reservation", if you will, when it comes to their hospital that they are operating at.

Mr. ROWLAND. I am really concerned about the uninsured individuals who may put off getting needed medical care, and based on what you are telling me now, those are the people that are most at risk in the scheme that we are talking about here.

Mr. CHAFIN. Well, I don't know whether they are at risk. When we talk about cost shifting, they are the shiftee, so they are going to pay the premium.

Mr. ROWLAND. What is the average profit margin of a proprietary for-profit hospital?

Do you have any idea?

Mr. CHAFIN. We have seen numbers of 1 to 2 percent; that type thing.

Mr. WILSON. Humana's profits are between 6 and 6.9 percent.

The question was for-profit hospitals—I don't know what they are for for-profit.

Mr. ROWLAND. The average was 1 to 2 percent?

Mr. WILSON. That is for hospitals across the board.

I am not sure for non-profit hospitals. They don't earn a profit, but they have to generate a surplus at some point or they can't continue to operate.

Mr. SCHAFER. The 1 to 2 percent is for-profit hospitals.

Mr. ROWLAND. There is a difference—not-for-profit hospitals make a profit also.

Is there a difference between those——

Mr. CHAFIN. We haven't done that kind of analysis.

Mr. ROWLAND. I appreciate the hard work that you have done on this.

Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman.

The gentleman from New York, Mr. Lent.

Mr. LENT. Thank you, Mr. Chairman.

There are a certain number of admissions in most hospitals that pay nothing; is that not correct?

Mr. WILSON. Yes.

Mr. LENT. And when hospitals take care of people—let's say somebody comes in and they run up a $40,000 hospital bill for 2 weeks of some sort of intense medical care, and the person is uninsured and there is no hope that that person is going to pay, the hospital has to pay, make up that cost someplace, does it not?

Mr. WILSON. Yes, it does.

Mr. LENT. I am just glancing at the Chairman of Humana's testimony.

He is going to testify later today, but he doesn't seem to deny these tremendous markups.

He indicates that we are talking about an accounting practice rather than fraud.

Is that true?

Mr. WILSON. We have made no allegations of fraud whatsoever.

Mr. LENT. Are we talking about accounting practices here—because you say Humana's profit is 6 to 6.9 percent, which seems like a fairly modest profit.

That is the bottom line.

They may charge $7 for a Tylenol tablet, but when you add up all of the net profit items and the net loss items, the bottom line is they make a profit of about 6 to 7 percent.

Mr. WILSON. Yes, that is true.

Mr. LENT. So that if they didn't have this sort of an accounting system—and I am bewildered by it—but if they didn't have this kind of accounting system they would probably go out of business?

Mr. WILSON. That is where we disagree.

They have to make up the losses sustained from people not paying their bills.

However, it is by no means clear that that kind of loss recoupment requires that they understate their room rate, which Mr. Jones' statement says they do, and shift that cost to ancillary items.

Mr. LENT. Would you agree that hospitals get paid by Medicaid only about 70 cents of every dollar of actual cost of care?

Mr. WILSON. I couldn't agree because I have no idea what it is actually costing hospitals to provide care for a Medicaid patient.

We have seen their cost to acquire certain items and the amount that they charge a patient for that item, which is what they would charge a Medicaid patient, and that there is sometimes up to a 2,000 percent markup, and 900 percent markups are not unusual.

So I couldn't agree that the Medicaid patient only represents 70 percent of their cost.

I would probably agree——

Mr. LENT. I said a hospital that has a Medicaid patient, a typical Medicaid patient only recovers about 70 cents on every $1 of actual costs.

Mr. WILSON. I agree that they might recover 70 cents of every dollar that they actually bill, or that they actually charge, but I would have trouble with the notion that they only recover 70 percent of every dollar that it costs them to provide for that patient.

Based on the accounting system that we have seen, I am not sure how they can compute the cost of caring for a particular patient.

Mr. LENT. I am wondering, if you were an insurance company adjustor or you worked at HCFA, and they have tens of thousands of greeneye shade types there pouring over hospital bills—they don't go through the 25 pages of individual charges, $6 for Kleenex, $9 for Tylenol—they look at the bottom line, do they not?

Mr. WILSON. Absolutely.

As Mr. Chafin pointed out, that is part of the problem. They really don't know what it costs the hospital to acquire these items and to deliver them to the patient.

They see the global picture of what the hospital is charging particular patients.

Mr. LENT. If you add up all of the overcharges, and admittedly $6 for a box of Kleenex or $7 for a Tylenol tablet sounds like an overcharge, and then you balance them against all of the undercharges where they don't recover on a dollar-for-dollar basis, or where they have a high percentage of Medicare patients because the hospital is located in an inner city and they have a great many undercharges.

We ought to be looking at the final bill.

Isn't that what insurance companies and HCFA look at?

Mr. WILSON. Yes.

Let me point out that health care costs, if that is the final bill that you are looking at, is 12 percent of our gross national product and projections are that it will go to 16 percent by the end of the century compared to Western Europe and Japan at about 9 percent.

So looking at the global picture, I think, is the right thing to do.

When you do that, I don't think the picture becomes much more reassuring.

Mr. LENT. Do you think from the studies you have made on Humana that insurance companies and the Federal Government are being ripped off or being overcharged by Humana because of these individual items, or do you think the HCFA people and the insurance people looking at the bottom line——

Mr. CHAFIN. We are saying that they are overcharging us within these items and asserting they are subsidizing us in room rates.

We are asking why.

Are they gaining more revenue out of this?

Mr. LENT. The DRG system that HCFA has decided on, I guess it was 6 or 7 years ago, pays for hospitalization in a completely different way than you folks are looking at the cost of a hospital stay.

They say if a male in Chicago, in a Chicago hospital spends 10 days in a hospital for an appendectomy, that is Code 5, let's say, and the cost of that should be $10,000.

They pay the $10,000.

This is a hypothetical figure I am using.

They don't look at how much that hospital may have itemized the Tylenol pill or the box of Kleenex in the room.

Mr. CHAFIN. There is a cost element because next year they want an adjustment upwards.

How much should that upwards adjustment be if you don't know what the costs are?

Mr. WILSON. The DRG was probably set in the first place based on hospital cost data that, as we have seen, can be manipulated to achieve the revenue base that the hospital wants.

Mr. LENT. If these hospitals are manipulating data to get higher buyouts from insurance companies and from HCFA on Medicare and Medicaid patients; why are so many hospitals going out of business?

Hospitals in Chicago and New York City are closing down.

Mr. WILSON. Not all hospitals are as good at it as others.

Mr. LENT. Does Humana charge more in the aggregate for a typical patient stay than does a non-profit hospital?

Have you found that in your investigation?

Mr. CHAFIN. They will be above some and below some.

Mr. LENT. Compare Humana with a stay in Georgetown Hospital or George Washington, Capitol Hill Hospital.

Is Humana charging any more or is it charging less?

Mr. CHAFIN. Under the DRG system, they will be paying the same.

The individual that Congressman Rowland talked about who actually gets hit with these patients charges—what did the patient go in for, how many heating pads were used? How many crutches were used? How many bags of ice were used?

If we talk about room rates, that is the whole point. These room rates are no base for comparison.

It comes down to all these ancillary patient supply charges.

Mr. LENT. They may be undercharging for the room rate and overcharging for these items.

Mr. CHAFIN. Why would they do that?

Mr. LENT. In order to realize some sort of a profit.

Mr. CHAFIN. Because if they charge the actual cost of the room rate, no one will take the room?

Why can't they put the patient charge with the room rate?

Mr. LENT. We are really criticizing their accounting practices, are we not?

Mr. CHAFIN. At the very beginning, yes.

Clearly this is misleading.

Mr. LENT. Do other hospitals have these kinds of accounting practices?

Mr. CHAFIN. Absolutely.

The American Hospital Association has put together based on the data they have collected a profile of what a typical hospital is doing.

A typical hospital is going to incur costs of $14,700,000 in room costs in a year.

They are only going to bill $12,500,000. The are going to lose $2.2 million which represents the rooms, if you will.

Mr. LENT. This is what I am pointing out to you.

Mr. CHAFIN. They are losing money on the room. It is a loss-leader.

Then they are going to turn around to once the patient is in the room in terms of medical supplies, the typical hospital will have $1.3 million in cost in medical supplies and charge $4.2 million for it.

They are going to have $1.8 million in cost of drugs that they are going to charge their patients $6.5 million for.

So, yes, they are providing a loss leader——

Mr. LENT. When you add up all the overcharges and understand charges, in the end, the bottom line is them made a 6 to 7 percent net profit at Humana, and other hospitals do even below that, 1 to 2 percent?

Mr. CHAFIN. Right.

You have to remember, right here before this subcommittee in 1984-85, we held hearings on General Dynamics.

They needed to be bailed out to the tune of a billion dollars on its defense contracts, but we still questioned a quarter of a billion dollars in their overhead charges.

Just because the company wasn't making money didn't mean that all the dog boarding and associated overhead charges that they were incurring were reasonable and valid.

So we took that quarter of a billion dollars from them.

If we are going to manage to the bottom line, if you are losing money, it doesn't matter how you try to generate revenues, then our investigations of General Dynamics and EPA Superfund contractors, I guess, were misguided.

Mr. WILSON. In Mr. Jones' statement, he says that the best yardstick ought to be the average cost per patient stay.

I submit that that is a pretty poor yardstick unless you somehow adjust it by the types of patients and the illnesses that they are coming into the hospital with.

If you are able to attract the "worried well," people pretty healthy, who are in there for relatively non-serious conditions and who are insured, that statistic will look very good.

Your average stay is not going to be very long, and will not be very expensive.

On the other hand, if you have to take AIDS patients off the street, your average cost for that patient is going to be very high because they are very sick.

What Humana, it seems to me, has been able to do very effectively, and I am not critical of this, is that they have located in areas where they are able to attract the relatively insured payor who isn't desperately ill.

Mr. LENT. Thank you.

Mr. DINGELL. The time of the gentleman has expired.

The gentleman from Ohio, Mr. Eckart.

Mr. ECKART. Thank you very much, Mr. Chairman.

Dennis and Jim and Bruce have done their usual good job and the subcommittee owes them a debt of gratitude.

I note with interest the asking of questions by the witnesses of the interrogators.

It is a refreshing opportunity for us.

You try to put in perspective part of the debate.

Bruce, particularly, I think the last thing I heard you say is, if you do not appropriately apportion costs, it is a lot like other places where you have been in the last 6 years and that is what we are trying to get to, if I understood your comment.

Mr. CHAFIN. That is right.

Mr. ECKART. Did you say "shiftee" or "shaftee" a few minutes ago?

Mr. CHAFIN. I hope I said shifting.

Mr. ECKART. Either word may be appropriate in this process.

I have two questions that are almost generic in nature, and I would appreciate the staff's response.

Is what you investigated at Humana systematic to hospitals across the board?

Do you have any reason to believe they are any better or any worse than if you looked at any collection of 60 or 70 hospitals?

Mr. CHAFIN. We have no reason to believe they are any different. We believe they are, in fact, typical.

From Humana's standpoint, it is unfortunate that their data were what was provided to the subcommittee.

We will be hearing from a panel on other hospital data this afternoon.

Mr. ECKART. Is this a case study?

Mr. CHAFIN. Exactly.

Mr. ECKART. I didn't know if we were making a point beyond that.

Dennis, let me ask you, you mentioned—was it high visibility items that was alleged——

Mr. WILSON. Bruce mentioned that.

Mr. ECKART. 7-11 does this, Hecht's does this; they are called "loss leaders." They get you in the door. Is that how you could characterize some of these things?

Mr. CHAFIN. Exactly. The American Hospital Association used that example. They said it is no difference than McDonald's offering you a 19 cent hamburger. We said there is a big difference because you buy the 19 cent hamburger and they try to charge you $10 for the fries and coke. You can take your hamburger and go to

7-11 and get your coke. When I go into a hospital for a $49 room——

Mr. ECKART. You are flat on your back——

Mr. CHAFIN. And I can't go to 7-11 for my ice, my saline solution, my eyepatches, my crutches or anything else. I am captive, and I don't even know it because as they are wheeling in a bag of saline solution, do you ask what they are going to charge you for it? When you are in 7-11 with the loss leader, you see the prices of everything else and you can take a hike if you want.

Mr. ECKART. My last question, did you study, do you know, what the comparison on this case study might be if we were looking at for-profit versus not-for-profit hospitals?

Mr. CHAFIN. No, because we got one case study. We have seen enough generic data to realize that they are typical, not atypical, but literally our detailed data are just on one hospital, one chain, and it is for profit.

I think there is a lot of work here that needs to be done as we expand out.

Mr. ECKART. I would concur. I think that is a very healthy place for our next inquiry, because I suspect that the for-profits probably see a lower percentage of the uninsured, of Medicare, and Medicaid patients—I think the more you start turning over a few more rocks, the situation I suspect is going to be less pleasant and not more pleasant. I think you have kicked us off in a correct direction and I appreciate the staff's work here.

Mr. WYDEN. Would the gentleman yield?

Before we leave, I want to pick up on the point Norm made, because I think the issue of the accounting practices is certainly very important, and one we are going to want to study.

But I want to make sure that we are clear that the central problem here is that there is a disconnect between price and cost in the analysis that you have done, and because there is that disconnect, it is hard to control costs overall, because you can't look for alternatives, you don't know what the whole package of services might cost; is that correct?

Mr. CHAFIN. That is correct.

Mr. WYDEN. I thank the gentleman for yielding.

Mr. DINGELL. The Chair recognizes the gentleman from Minnesota. There is a vote on. I will recognize him either now or after we come back in the vote. This choice is his.

Mr. SIKORSKI. I will do 5 minutes now, if that is all right.

Mr. DINGELL. The gentleman is recognized for 5 minutes.

Mr. SIKORSKI. Gentlemen, I too want to thank you. We heard this rationalization that Humana is doing these pricings, this cross-subsidization for the purpose of taking care of its losses because it is a charity operation, that they take care of the poor and they are taking care of all these nonpays and they are balancing off those that can only pay a little bit. Is it true that they are located in places where they have a tremendous burden, like public hospitals and a bunch of other for profit urban hospitals and reservations and others across the country? I see them concentrated in the South-Southwest where there are a lot of retirement people and a lot of private and they go for the bucks.

Mr. CHAFIN. You are correct on the demographics, but any city in America is going to have some individuals that are indigent and they have about a 3 percent——

Mr. SIKORSKI. So they have a 3 percent loss. If we are going to listen to this justification, we are going to listen to it from virtually every hospital in the country, then?

Mr. CHAFIN. I don't believe you are going to hear Humana attempt to justify the supply and the ancillary prices based on their losses with indigents. I think you will see them try to justify it based on the overall revenues including either losses in room rates or breaking even with room rates and that is the more trying to balance the overall books, with the indigent care being a part of that.

Mr. SIKORSKI. So no crocodile tears here.

Mr. CHAFIN. For the indigent, sure.

Mr. SIKORSKI. No, for the pricing system.

Mr. Chafin, you state in your testimony today that Humana uses ancillary or supply items to generate excess revenues to cover revenue short-falls in other areas of the operation. You have stated that. Is it a typical or an atypical hospital system?

Mr. CHAFIN. We think they are typical and that was the data we supplied Mr. Lent, based on what the American Hospital Association shows for a typical hospital.

Mr. SIKORSKI. And you believe they are doing this in order to take care of other costs elsewhere, getting people in and once they are in there, they are in no condition or inclination to ask about these other charges?

Mr. CHAFIN. Absolutely.

Mr. SIKORSKI. And this is industry-wide?

Mr. CHAFIN. Yes.

Mr. SIKORSKI. Are they gaming the medical consumers——

Mr. CHAFIN. There are two levels of gaming, if you will. The first level would be, are they increasing revenues this way? That is, I think, what we are talking about in terms of having the GAO look at these cross-subsidizations within a given patient, how that is affecting the patients' overall bill and is it revenue-neutral.

Second, the fact they are taking them out of the high profile areas into the lower profile areas, I think we can already see that level of gaming, and the American Hospital Association acknowledged that when we were asking why are you getting it off the room rate and putting it into these charges?

The first answer was when a reporter calls, they want to know what your semi-private room rate is.

Mr. SIKORSKI. On the supply markup issue, you see an inverse relationship between the cost and the markup, the more visible and expensive the item is, the less the markup occurs?

Mr. CHAFIN. Exactly.

Mr. SIKORSKI. Do you think that is a function of visibility, reporters start asking about——

Mr. CHAFIN. If you are going to go beyond the room rate, you are going to hit other high profile type items.

When you are doing your market basket for your story, would you ask what you charge for a cotton swab?

Mr. SIKORSKI. If I went to business school, health management, and came out, this kind of problem would create real problems for management control for me; would it not, because if the relationship of the markup to the cost is inverse, how do I control costs increase profit——

Mr. CHAFIN. It is a double-edged sword. If I am the manager, it creates a problem for me in terms of controlling cost. But it gives me a benefit in the sense of giving me the flexibility and variability with my resources, where I am going to generate them from. This is the analogy Dennis used of stepping on the balloon.

It gives me insurance against somebody coming in and stepping on that balloon in one area and reducing my revenues.

Mr. SIKORSKI. You have told us the problem and how it works its way in the specifics. Tell us who is paying for this, this problem in the pricing mechanism.

Mr. CHAFIN. One of the things we want the government to do is look at whether this is revenue neutral or is it, in fact, generating more revenue.

We are talking about whether it is generating more cost or not controlling cost. When I keep the costs down, then when we come in with our cost numbers and our cost basis to talk about DRG's or negotiate with Blue Cross-Blue Shield or anyone else, it affects everyone.

Mr. SIKORSKI. My last question: The expectation here is that you got public payors and private payors—they all get down to real people.

The American taxpayers pick up the Medicare program and the Medicaid program; State taxpayers pick up the Medicaid program, as well. But those are package kinds of deals, and there are stronger cost controls at least, we believe, in those.

Mr. CHAFIN. That is where I disagree. There is not stronger cost controls. There are stronger revenue controls, and the cost control is what is missing.

Mr. SIKORSKI. But we also have employees who are in package group deals, insurance deals, who are paying additional costs because of this, as well; is that not the case?

Mr. CHAFIN. Absolutely.

Mr. SIKORSKI. It is our indication that they may be paying a greater burden of this than Medicare?

Mr. CHAFIN. I think you will see a statement in Mr. Jone's testimony later today where he says the government has turned him into the tax man.

It will be interesting to find out, since he is now the tax man in shifting these, how does he do it.

Mr. SIKORSKI. He is shifting it over to Blue Cross——

Mr. CHAFIN. Or to the individual that you just described.

Mr. SIKORSKI. Thank you.

Mr. DINGELL. The time of the gentleman has expired.

We are going to recess at this time and go to the Floor to vote.

The Chair—I think we are probably finished. There may be some questions for the record, but I suspect that it is appropriate to excuse the panel.

Gentlemen, we thank you. Your work is up to the usual high quality we expect of the staff, and we appreciate your assistance to the subcommittee.

The subcommittee stands in recess.

[Brief recess.]

Mr. WYDEN [presiding]. The subcommittee will come to order.

The next witness scheduled for the subcommittee is Mr. Lawrence B. Swayze, President, DeltaMed Corporation, Richardson, Tex.

Mr. Swayze, if you will come forward, we will attend to the formalities and—you are evidently aware of the practice of the Oversight and Investigations Subcommittee to be sworn as a witness.

Do you have objections to being sworn as a witness?

Mr. SWAYZE. No.

[Witness sworn]

Mr. WYDEN. Let me also, as you can see, advise you of your rights before the subcommittee. You have the right at all times to be accompanied by counsel. I gather you do not desire to be represented by counsel today?

Mr. SWAYZE. That is correct.

Mr. WYDEN. A copy of the committee and subcommittee rules are at the table. We will put your prepared remarks into the record in their entirety, and if you could summarize your principal concerns for us, that would be very helpful.

TESTIMONY OF LAWRENCE B. SWAYZE, PRESIDENT, DELTAMED CORP.

Mr. SWAYZE. Thank you very much.

DeltaMed Corporation has more than 20 years experience in the categorization and pricing of medical services. During the past 8 years, DeltaMed has focused on developing computer systems to automate the analysis of medical prices.

The hospital setting represents 80 percent of basic medical expense. The hospital itself accounts for 60 percent, and the rest is doctor fees for in-hospital work.

Although separated by tradition, doctors and hospitals are inextricably interlinked. Neither can function without the other. If the medical business has been developed last week, they would be part of the same organization and save overhead.

We have heard how 20 years ago most of the hospital bill was the room charge. All other charges accounted for less than 20 percent. These other charges, called ancillaries, are for medications, supplies, equipment, lab tests and x-rays.

Insurance policies were written to pay a pre-set room rate, thereby establishing control over 80 percent of the bill. To simplify administration, ancillaries were covered in full unless they represented patient convenience items like telephone charges or haircuts.

Since then, a lot of things have happened that affected hospital charges—the Medicare program, increased levels of technology, more intensive medicine, sophisticated computer systems and improved accounting practices.

Each ancillary service is categorized in hospital computer systems by a general ledger code sometimes called a basic unit of serv-

ice (BUS). These code sets drive inventory, purchasing and accounts receivable.

It is the BUS and the price assigned to it that determines the amount of the hospital bill. These BUS codes reflect services and supplies consumed at the hospital. They are standard. Many items are bought on the open market and resold.

Basic units of service are the nuts and bolts of hospital care. Outside the hospital they have been rendered invisible. Insurance payments are the primary source of hospital income. Hospitals submit a detailed itemization of charges along with each insurance form, but individual prices are not examined. The BUS prices are hidden by simplified payment procedures. Claims payment systems require two amounts: First, accommodation charges so the room rate can be applied; and second, everything else.

The fact that an 80 cent surgical needle has been priced at $143 never registers and is lost forever.

Put yourself in the hospitals' position, (a) all ancillary services are covered, and (b) any amount you bill is paid. Your prices are not questioned. For all you know, the hospital down the street charges more.

The knowledge that one can unilaterally increase price is an irresistible temptation. Price raises will occur as soon as a need for extra money can be discovered and justified in the vendor's mind. This rationalization process acquires a life of its own. It becomes self-perpetuating in the hands of accountants and consultants whose fees are paid from the new revenue.

The process is the same whether the facility is profit or nonprofit. Building programs, increased staff, financial reserves, and stock performance all depend on the BUS price.

By the time higher salaries and the health club are entrenched, the rationalization process has fully matured. The need for more money is now institutionalized and the needle really does cost $143.

Cost is a not a major consideration in setting prices. Hospitals do not use bottom-up cost accounting. Budgets are derived from past expenditures.

According to the consultants, price increases should be subtle. The room rate should be avoided because it can be easily compared to other hospitals and to analogous services like a hotel room. The trick is to identify high volume services that are unobtrusive. If your hospital is charging $650 for a CAT Scan now, and doing a thousand scans a year, a $100 increase will yield a theoretical $100,000. Since CAT Scans symbolize technology and have a high visibility factor, it might be better to increase the charge for "saline solution" by $5. Saline solution (salt water) is the liquid in those bags that hang from IV poles. Five dollars multiplied by 200,000 units will bring in a theoretical million dollars.

The additional income is theoretical because price increases affect patients, or more accurately their financing, differently. Self-pay and insured patients will pay the full amount, but the Medicare inpatient's payment is frozen. It's all in the math. To get a million dollars from saline, the price might be raised from $5 to $8 to offset the Medicare freeze. This is called cost shifting, and the BUS Code is the tool used to shift. Tinkering with unobtrusive charges causes inconsistencies in price relationships. A hospital

charging $143 for a surgical needle may charge less for a chest x-ray, a service that has significant investment and labor components.

The price and charge list of Humana Suburban Hospital in Louisville, Ky. is typical. The 1,468 items on the list are for medical supplies. Charges for these items make up about 12 percent of a hospital bill.

The rest of the charges—laboratory tests, x-rays, medication, accommodations—are expressed by 10,000 other BUS Codes.

If you sum up all prices and all charges, there is an unweighted markup of 2.5 to 1 or 250 percent. However, the markup on an item basis varies from 40 percent on some low-volume items to several thousand percent on some disposable high-volume items. For example, saline solution is marked up 55 times. The leveraged markup for the entire hospital is the sum of the difference in price and charge for each item times the number of items sold.

There is nothing wrong with pricing to maximize the revenue. It is an integral part of any business strategy. The problem is the buyer side of the equation does not work well.

The question is not why Humana marks up and resells medical supplies. They do it to make money. The question is, why do insurance companies pay these charges?

Thank you.

Mr. WYDEN. Well, thank you very much, Mr. Swayze.

I think you could tell from my opening statement that I very much share your view on the matter of the private insurance companies. I think that is one of the things that I think members on both sides of the aisle are going to have to see, that this system has not been jerry-built by accident.

It happens because private insurance companies are willing to just run the cash register and pay these bills.

You have done the subcommittee a substantial service. Let me, if I might, just ask you a few additional questions to amplify on your excellent statement, and we thank you for your cooperation.

You mentioned the question of the basic unit of service, and it's categorized in the hospitals' computer codes. And I gather you have a data base that indicates patient charges associated with BUS items from all over the United States.

Mr. SWAYZE. That is correct.

Mr. WYDEN. How big is your data base?

Mr. SWAYZE. The data base represents 6,000 hospitals on which we have charge masters on approximately 2,000, representing over 150,000 items purchased.

Mr. WYDEN. How many of the hospitals in your data base are for-profit hospitals?

Mr. SWAYZE. As a percentage, I am not sure.

Mr. WYDEN. Let me ask if you found whether the markups discussed today at Humana were representative of hospitals around the country?

Mr. SWAYZE. Very much so.

Mr. WYDEN. How does Humana specifically compare in its markup of the items that the subcommittee is looking at?

Mr. SWAYZE. On the items that we looked at as we compared them to other hospitals, we found them to be in the range of 10 to 15 percent higher.

Mr. WYDEN. Ten to 15 percent on top of what you found the representative charges that come out of your data base system?

Mr. SWAYZE. That is correct.

Mr. WYDEN. Do you believe that these markups are cost driven?

Mr. SWAYZE. No.

Mr. WYDEN. Do you believe that the hospitals know what the cost is associated with these items?

Mr. SWAYZE. There is no cost-to-price relationship.

Mr. WYDEN. How do you have cost control, a bottoms-up pricing system if you don't know what the cost of your items are?

Mr. SWAYZE. I don't think there is any cost control.

Mr. WYDEN. Why do you believe that hospitals would be attempting to make additional revenue in areas such as the items on the basic unit of service area?

Mr. SWAYZE. The items that we look at, most of the services that we see, we have heard here today that some items are cross subsidized.

I do believe that the room rate is cross subsidized, but I am not sure that any of the other items are cross subsidized.

They all seem to have extreme markups.

Mr. WYDEN. Would it be fair to say in your analysis that the more conspicuous kinds of services, hospital room rates, MRI's, are the ones that have the lower prices and the other items would be charged more for?

Mr. SWAYZE. Yes.

Mr. WYDEN. Do you believe there is something of a shell game going on with the cost area that we are looking into?

Mr. SWAYZE. Yes.

Mr. WYDEN. The subcommittee asked you to look at specific Humana items found at Suburban Hospital in Louisville. What can you tell the subcommittee regarding specific examples of saline, dextrose and catheter kits regarding their associated markup at Humana and how they would compare with other examples in your data base?

Mr. SWAYZE. We looked at three specific categories. The first one are catheter kits which are fairly standard items. We examined six different items showing the lowest markup at 3.2 times cost and the highest markup at 73.5 times cost.

All these that I am talking about we see the same kinds of markups from other hospitals.

The second one we looked at were IV solutions which had a low of 29.4 times cost and as high as 74.8 times cost. Once again, we feel these fall in line with our data.

The last one is sodium solutions where the low was 24.9 times cost and the high was 91.2 times cost.

Mr. WYDEN. One of the arguments that the subcommittee has heard repeatedly is that these problems are in some way related to the patient mix at a hospital, Humana or presumably most other hospitals around the country.

Are you finding, though, that it is not so much a question of patient mix but it is also a question of the charges even varying for a particular patient?

Mr. SWAYZE. We like to look at it from patient to patient and say that patient mix does not occur when it gets down to the level of what services were rendered to what inpatients.

Mr. WYDEN. So overall, you would say it would be fair to contend that it is not primarily a cross-patient problem, not primarily a patient mix problem, but it is something related to charges for a given patient?

Mr. SWAYZE. That is correct.

Mr. WYDEN. How would you respond to the suggestion that these practices reflect higher quality health care?

Mr. SWAYZE. I don't see quality having anything to do with that.

Mr. WYDEN. What is the point of playing the charging practice game within a given patient's game?

Mr. SWAYZE. I think that game is played from patient to patient. So thereby it gets played across the boards.

Mr. WYDEN. Does it have to do with trying to achieve a predetermined level of income?

Mr. SWAYZE. Absolutely.

Mr. WYDEN. What effect do you think these practices have on containing costs?

Mr. SWAYZE. I don't think these practices can any way help contain costs.

Mr. WYDEN. How do patients counter this? I have been someone who would like to see patients have additional leverage in the health care marketplace. I think this subcommittee has moved in areas such as Medigap insurance to give the consumer additional leverage.

There were 2,000 policies out there, and then a group of us, under Chairman Dingell's leadership, got a bill passed.

By the end of this year, we are going to have 10 policies. So there is going to be an opportunity for the consumer to have some leverage in that area.

Do you think the consumer can have leverage in the kinds of things we are talking about today as it relates to supplies in a hospital?

Mr. SWAYZE. I don't think on a consumer base they can have an effect. On a side base, no.

Mr. WYDEN. Who would have financial clout? You and I have agreed that the insurance companies have financial clout because they pay the bills. Does anybody else in this system that we have today have real financial clout over these kinds of questions?

Mr. SWAYZE. Yes. I think there is an awful lot of competition in health care, and we feel that smaller employers can have clout in their own way as much as insurance companies and larger national employers.

Mr. WYDEN. You have been very helpful.

As you can see, the members, we have another vote on the Floor, and I am going to have to go over and make this vote.

With your indulgence, I am going to ask Mr. Wilson, Minority Counsel, to ask any questions if he has some at this time.

We will recognize Mr. Wilson, and then we will have to take a break at that time.

Mr. WILSON. I have a couple of questions.

Yesterday Mr. Jones said that in response to the information that the shift in billing was from 80-20, the room rate to ancillary services had changed from 80–20, 20 years ago to about 15/85 today, said that the intensity of the ancillary services provided has changed and that is among the reasons that that ratio has shifted over the past 20 years.

Has your analysis led you to believe that intensity of ancillary services is a significant factor in that ratio change?

Mr. SWAYZE. There might be an intensity factor if you look at it as having more services rendered. Obviously you are getting more services rendered if it has reversed from 80-20 to 20-80. We would like to say to look at what services rendered and what was charged for that service.

Once again, I think we are back to the markup question again. I am not real sure what he means by intensity.

Mr. WILSON. Do you think that hospitals have the sophistication when considering their payor mix—when we talked to the American Hospital Association, we said what is the most important thing in terms of billing.

And they say, payor mix to determine what services, what ancillary items particular payors are most likely to use and to markup those items in their efforts to maximize revenue.

How sophisticated are hospitals in this area?

Mr. SWAYZE. Personally, we have not seen any programs that allow you to do that. We have heard of computer software that is used by consultants which will allow you to choose a revenue increase figure and then go down on a neutral, revenue neutral basis to pick out those high volume items, and then apply the price increase to those particular items.

Mr. WILSON. So you have heard of computer software that would allow you to do what I suggest?

Mr. SWAYZE. We have never seen those programs but have heard that they are in existence.

Mr. WILSON. Given the existence of these programs and the other measures that you have discussed, how difficult do you think it would be for hospitals to be able to price or to determine costs by item?

We have been told, for example, that they really don't know the cost of getting that eye patch, that bag of ice, that bag of saline solution to the patient.

They can sort of globally estimate it and do the mental calculations, but to have hard and fast figures, given their level of sophistication, how difficult do you think it would be for them to be able to accurately measure that cost?

Mr. SWAYZE. I think it would have to be approached from a different situation. I think that taking what it cost last year and trying to analyze on a top-down basis is where we are today.

If you are going to go on a bottom-up costing basis, we think that you need to apply time and motion studies, et cetera, to specific areas within specific departments and then possibly extrapolate to other services that are related to that.

I am just not sure how much in terms of cost that might be.

Mr. WILSON. Mr. Chairman, I have no further questions.

Thank you very much.

Mr. WYDEN. I thank the gentleman.

Let me convey the regrets of particularly Chairman Dingell. This is a very hectic day on the Floor with the Crime Bill and everything else. You have been enormously helpful to the subcommittee, and we will want to work closely with you in the days ahead.

Would you like to add anything?

Mr. SWAYZE. No.

I appreciate the opportunity.

Mr. WYDEN. The subcommittee will stand in recess for 10 minutes.

[Brief recess.]

Mr. DINGELL. The subcommittee will come to order.

The Chair notes that we have concluded the testimony of the first panel. We are now prepared to hear the testimony of the next panel.

The first panel member is Ms. June M. Hutchinson, R.N.; also Ms. Roberta D. McCauley, L.P.N.; and Ms. Rita E. Jacot, R.N.

Ladies, we appreciate your courtesy to the subcommittee and your presence here today with us. You have heard the Chair discuss with the witnesses who appeared before, with regard to the rules under which the subcommittee functions.

As you know, it is the policy of this subcommittee that all witnesses testify under oath. The Chair inquires, do any of you have any objection to testifying under oath?

Ms. HUTCHINSON. No.

Ms. MCCAULEY. No.

Ms. JACOT. No.

Mr. DINGELL. Very well. The Chair advises that in view of the fact that you will be testifying under oath, it is your right to be advised by counsel as you appear here.

Do any of you desire to be advised by counsel in connection with your appearance at this time?

Ms. HUTCHINSON. No.

Ms. MCCAULEY. No.

Ms. JACOT. No.

Mr. DINGELL. Very well. The Chair advises that copies of the rules of the House, the rules of the subcommittee, and the rules of the committee are there at the committee table before you in the red and orange books, which you will see in front of you, to advise you both on the limits, on the powers of the committee, and also on your rights as you do testify here before us.

The Chair, in view of the fact that you have no objection to testifying under oath, if you would each please rise and raise your right hand.

[Witnesses sworn.]

Mr. DINGELL. You may each consider yourself under oath.

The Chair advises that we will receive your testimony.

Ms. Jacot, we will commence with you, and then—OK, very well, we will receive your testimony now, and then such comments as Ms. McCauley and Ms. Hutchinson choose to make. You are recognized.

TESTIMONY OF RITA E. JACOT, FORMER NURSE, HUMANA SUBURBAN HOSPITAL; ROBERTA D. McCAULEY, NURSE, HUMANA SOUTHWEST HOSPITAL; AND JUNE M. HUTCHINSON, FORMER NURSE, HUMANA AUDUBON HOSPITAL

Ms. JACOT. Thank you, Mr. Chairman.

The testimony that we just heard focused on amazingly high markups of hospital supplies, but what we would like to tell you about is our first-hand experience with Humana's billing practices in Louisville.

In this case, patients are frequently billed for supplies that they never get, and sometimes they are billed twice for the same supplies. We would like for the subcommittee to understand how Humana does this.

Twice a day our hospital Purchasing department fills a four-wheeled cart, called a Par-level cart, with a predetermined set of medical supplies. These include such things as gauze pads, dressings, IV supplies, saline solutions, catheter kits, and specimen kits. Purchasing brings the prestocked cart to our unit and drops it off. Each item on the cart has a yellow sticker, similar to this, with an inventory number on it.

For the most part, no one on the unit verifies whether what purchasing puts on the cart is correct. From time to time, one of the nurses has checked to see if the right supplies were delivered, only to find that some are missing.

The next day purchasing sends us a list of so-called "lost charges." These are charges that purchasing says cannot be accounted for when they get the cart back and attempt to reconcile what is left on the cart with what they say was originally on the cart. To our surprise, some of those lost charges often include items never put on the carts to begin with.

When we protested to purchasing that we never received the particular supplies, purchasing tells us we are responsible for these charges. At this point, a patient is picked and is then billed for them.

What we have also found is that sometimes the cart is short of items we requested, because they are out of stock or have been back-ordered. That is not so unusual in and of itself, but what is unusual is that those items, too, show up on our lost-charge list; and some patient is billed for the supplies that the hospital doesn't even have.

Charges can also be lost in several other ways. For example, a doctor may come to the floor, take items off the cart and go directly to the patient's room, use the item, throw the stickers out, walk off the floor, and never let anyone know that the items were used. They would show up on our lost-charge list the next morning, and we would have to try and find a patient to bill for it.

A third way is nurses putting the stickers on their uniforms, because they are really busy and they don't have the time to take the stickers off at that moment and place them on the card belonging to that patient. For example, if a patient is having difficulty breathing, you have to use suction immediately. You run to the cart, grab what you need—if there is that item—pull off the stick-

ers, stick them on your chest, and run back to the patient, and take care of the patient.

In the meantime, you may get a patient who has started to bleed and needs to have a pressure dressing applied immediately. Again, you run to the cart, grab what you need, pull the stickers off, and stick them on your uniform again.

When it finally settles down, you finally sit down and try and remember which patient got what. Unfortunately, sometimes this pace goes on for 5 or 6 hours, so it is not as easy as you might think to sit down and remember which patient got what supplies.

Also, sometimes the stickers fall off when you are rushing from one patient to another, and you have lost them; and you have long since forgotten what you used. So there is really no way to account for those supplies; but they still end up on the lost-charge list the next day, and we have to find the unlucky patient to pay the bill.

A fourth way is that people from other floors may come to borrow supplies from our cart, saying they will return them as soon as they get theirs, or saying nothing at all. Often, they never replace them. Once again, those supplies show up on our lost-charge list.

A fifth way is that different shifts may take things from the cart and forget to charge their patients also. Then we are left basically guessing at what another shift has used with other patients.

The emphasis on finding someone to bill for lost charges is so great that sometimes people with no knowledge at all of where these supplies might have been used make arbitrary decisions. For example, in one case, a unit secretary who was off for a week got the lost-charge list from purchasing and then started charging patients for the items.

One way or another, those charges will be accounted for. Humana doesn't care who pays for it as long as they get paid.

Another form of lost charges is equipment that is billed for by the day. That includes IV pumps, which regulate intravenous fluids. A patient may be on it for 5 days, then have the dosage rate decreased so the pump is no longer necessary; but the pump stays in the patient's room or in a dirty utility room until it is picked up by medical supply, and, of course, the patient may get billed for each of these days that it is not being used.

Another kind of equipment that patients get overbilled for is the K-pad. It is a reusable heating pad that can provide wet or dry heat. It is used over and over again for a number of years. If wet heat is being applied, it simply involves pouring water on the side of the heating pad and then plugging it in. Humana's charge for accomplishing this simple procedure is $116 for installation and $33 per day thereafter.

Remember, installation essentially means my plugging it into the wall.

Many times, though, the motor doesn't work. Then a new K-pad pump is ordered. The patient ends up paying a second installation charge. To make matters worse, even if the heating pad that doesn't work is removed from the patient's room, the patient continues to get billed for the heating pad, $33 each day, if left in the dirty utility room.

While the charges to patients and the arbitrary assigning of supplies to patients that they may not have received is bad policy in and of itself, this by no means tells the whole story on quality of care in Humana hospitals. As you know, all hospitals, including Humana, have to be accredited by the Joint Commission for the Accreditation of Health Care Organizations, who notifies the hospital months in advance of the date of inspection. This organization, amongst other things, establishes standards for nurse-patient ratios, laboratory practices, record-keeping, and the like. The Joint Commission requires that each hospital establish the nurse-patient ration based on the patient's needs, type of illness, and the hospital personnel's experience.

Humana Hospital has internal written procedures consistent with those standards. However, in practice, Humana determines how many nurses they need based on sheer patient numbers, which means a medical-surgical nurse is required to care for 8 to 14 patients, regardless of the seriousness of their condition or the nurse's experience, when six patients should be the maximum.

Mr. Chairman, we have a copy of Humana's policy procedure for nurse-to-patient staffing from Humana Southwest Hospital. If you would like, we can supply it for the record.

Mr. DINGELL. I believe that would be very useful. If you would, we will see that it is inserted in the record.

Without objection, that will be done.

Ms. JACOT. We also have guidelines which Humana is supposed to use, but doesn't always, to set the number of nurses for each shift on 3 North at Humana Southwest Hospital.

Mr. DINGELL. I believe that would be useful for the record, also.

[The information follows:]

WORK# NUMBER: 611

*ADC

CENSUS:		0/3	4/5	6/7	8/9	10/11	12/14	15/16	17/19	20/22	23/25	26/27	28	29/30	31	32/33	34	35/36	37/39	40/43	44/46	47/48	49/58
7-3	NM	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	RN	1	1	1	2	2	2	2	2	2	2	2	2	2	3	3	3	3	3	3	3	4	4
	LPN	0	0	0	0	0	0	1	1	1	1	2	2	2	2	2	2	2	2	3	3	3	3
	PCA/NT	0	1	1	1	1	1	1	1	2	2	2	2	2	2	3	3	3	3	3	3	3	3
	US/MT	0	0	.5	.5	.5	.5	.5	.5	1	1	1	1	1	1	1	1	1	1	1	1	1	1
TOTALS:		1	2	2.5	3.5	3.5	3.5	4.5	4.5	6	6	7	7	7	8	9	9	9	9	10	10	11	11
3-11	RN	1	1	1	1	2	2	2	2	2	2	2	2	2	2	2	3	3	3	3	3	3	3
	LPN	0	0	0	0	0	0	0	1	1	1	1	2	2	2	2	2	2	2	2	2	2	3
	PCA/NT	0	1	1	1	1	1	1	.5	.5	1	1	1	2	2	2	2	2	2	2	3	3	3
	US/MT	0	0	.5	.5	.5	.5	.5	.5	.5	1	1	1	1	1	1	1	1	1	1	1	1	1
TOTALS:		1	2	2.5	2.5	3.5	3.5	3.5	4	4	5	5	6	7	7	7	8	8	8	8	9	9	10
	RN	1	1	1	1	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	3
	LPN	0	0	0	0	0	0	0	0	0	1	1	1	1	1	1	1	2	2	2	2	2	2
	PCA/NT	0	0	.5	1	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2
	US/NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS:		1	1	1.5	2	2	3	3	3	3	4	4	4	4	4	5	5	5	6	6	6	6	7
DAILY TOTALS:		3	5	6.5	8	9	10	11	1.5	14	15	16	17	18	19	20	21	22	23	24	25	26	28

Subject:

PATIENT CLASSIFICATION

Humana Hospital Southwest

POLICY
PROCEDURE

No. –

Effective Date / /

Page ...

POLICY: The Patient Classification system will organize, communicate, document, and refine nursing care.

PROCEDURE:

ACTOR	ACTION
Nurse Manager or Charge RN on the day shift	Will determine patient acuity based on the assessment of the patient's physical condition and needs using the patient acuity worksheet I.
	Transcribe number of patients under each category on the patient classification worksheet II and forward to the nursing supervisor by 1200.
	Any unusual circumstances, patients needing to be transported to another facility, balloon pumps, etc., should be noted under comments.
Nursing Supervisor	Will collect patient classification worksheet II from each unit.
	Will review acuity of patients and determine staffing numbers and skill mix.
	Any adjustments during the evening or, night weekend shifts will be made by the nursing supervisor.
Nurse Manager or Charge RN	Will make assignments according to acuity and nurses level of experience (more experienced nurses will care for higher acuity patients)

Authorized by:_____
Date:_____
Reviewed by:_____
Date:_____
Reviewed by:_____
Date:_____

PATIENT CLASSIFICATION WORKSHEET II
(MUST BE GIVEN TO HOUSE SUPERVISOR BY 1200)

DATE: _____
UNIT: _____
CHARGE RN: _____

PATIENT NAME & ROOM NUMBER												
Vital Signs												
Monitoring												
Activities of Daily Living												
Feeding												
IV Therapy												
Treatments/ Procedures												
Teaching												
Emotional Support												
Continuous Care												
Totals per pt.												
Acuity Category												

Acuity Table

Category I	0 - 12 points
Category II	13 - 31 points
Category III	32 - 63 points
Category IV	64 - 95 points
Category V	96 - 145 points
Category VI	146 and higher

Comments

_____
_____
_____
_____
_____
_____

PATIENT CLASSIFICATION

Humana Hospital Southwest
POLICY
PROCEDURE

No. –
Effective Date / /
Page

PATIENT ACUITY WORKSHEET I

Instructions:

Using the patient classification worksheets I & II, determine points for each patient. Write point value in appropriate box on worksheet II. The point values then must be totaled and a category given to each patient based on the acuity table.

VITAL SIGNS	POINT VALUES
V[redacted] V/S q10 or less q4h or x6	[redacted] 1
	[redacted] 2
q3h or x 8	3
q2h or x 12	4
Rectal or ax [redacted] q1h or x 24 or Apical pulse q10 or more	8
[redacted] Apical pulse qid or more	[redacted] 2
Femoral, pedal or popliteal pulse or FHT qid or more	2
Tilt test q4h or more	2
[redacted] post-partum or post delivery Newborn [redacted]	[redacted] 6
Post op V/S	

MONITORING

[redacted] I & O q8	[redacted]
q2h	8 2
[redacted] fundus [redacted] Circulation or funds ✓ q 2h or x 12	[redacted]
[redacted]	[redacted]
CVP or ICP (manual) q2h or x 12 Neuro ✓ q4 or x 6 q 2 or x 12	2
Cardiac/apnea/temp/BP monitor (not circulative) 3 6	6
Transcutaneous monitor/oximeter	6
A-line or ICP monitor or Swan Ganz set-up	4
A-line or ICP monitor reading q2h or x 12	2
q2h or x 12	4
Cardiac output tid or x 3	2
Ventilator see treatments	2

ACTIVITIES OF DAILY LIVING

Care age 11 or less (child)	6
[redacted] Care age 12 or more (adult)	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Peds recreation/observation - age 0-12	8

Subject:
PATIENT: CLASSIFICATION

Humana Hospital Southwest
POLICY
PROCEDURE

No. –
Effective Date / /
Page

TREATMENTS/PROCEDURES/MEDICATIONS	POINT VALUE
[redacted]	[redacted]
[redacted] 2h	
[redacted] circumcision or phototherapy	2
[redacted]	[redacted]
Range of motion exercises x 3	4
15 minutes	2
30 minutes	4
[redacted]	[redacted]
acw ✓ bcd ✓ suctioning	2
TEACHING	
[redacted] - group - per hour	2
EMOTIONAL SUPPORT	
[redacted]	[redacted]

Subject:
PATIENT: CLASSIFICATION

Humana Hospital Southwest
POLICY
PROCEDURE

No. -
Effective Date / /
Page

FEEDING

[redacted]
- age 5 or less - x 3 10
Infant/neonate bottle x 1 feeding 2
q4h or x 6 12
q3h or x 8 16
[redacted]
assist c meals p cardiac cath 4

IV THERAPY

[redacted]

Subject: PATIENT: CLASSIFICATION	Humana Hospital Southwest POLICY PROCEDURE	No –
		Effective Date / /
		Page

CONTINUOUS CARE

Patient requiring 1:1 coverage all shifts	96
Patient requiring 2:1 coverage all shifts	146

ACUITY TABLE

Category	I	-	0 - 12	points
Category	II	-	13 - 31	points
Category	III	-	32 - 63	points
Category	IV	-	64 - 95	points
Category	V	-	96 - 145	points
Category	VI	-	146 - 262	points

Ms. JACOT. It has nothing to do with the patient's needs, but, Mr. Chairman, I can assure you that when the Joint Commission shows up for its announced review, Humana will have its nursing staff in accordance with the Commission's requirements.

But that isn't the only way that Humana uses blue smoke and mirrors when it comes to the Joint Commission's requirements.

The Joint Commission requires nurses to prepare patient care plans daily. They are supposed to include any information on patients' needs in terms of dressings, exercise needs, whether they are getting intravenous fluids, daily laboratory tests that are needed or x-rays or diagnostic procedures. They are also supposed to be updated each day. This almost never happens—unless, of course, you know that the Joint Commission is coming. Then Humana will pay us overtime to go back and fill out these care plans after the fact in order to meet the requirements. Every patient ends up with a care plan, but those plans may or may not reflect the care that was required or received.

And finally, we know that the Joint Commission is coming by the inhuman push from management personnel on our housekeeping staff to clean up normally junk-filled closets, shampoo normally stained carpets in the patients' rooms, replace curtains and blinds, and replace broken beds and other furniture and equipment that is in disrepair.

When you see maintenance and housekeeping haul off equipment normally stored in hallways, you know the Joint Commission is not far behind, because these practices are breaches of their regulations. When the Joint Commission leaves, all that equipment returns to the halls, and everything is back to normal. In fact, this statement can be backed up by the pictures that we have of the moving vans hauling things away.

Mr. Chairman, in closing, I want to thank you again for caring about these issues. However, given the events taking place in our Capitol these days, you cannot blame the average individual for being skeptical about the effect of one's voice in high places or that those elected really care about anything other than power, position, or prestige.

We are here because we believe we can effect change, that our voices do count, and that not all of Congress is inept or callous. We can create an equitable health care system that doesn't favor the rich, which provides quality care for all citizens, doesn't bilk the government, and doesn't allow private health care corporations to overcharge the consumer, to understaff to create profit, or to pull the wool over the eyes of the agencies meant to regulate hospitals.

We cannot speak for other nurses who are not here today, but we would rather take the change of being blackballed in our community, where one hospital corporation dictates what our elected officials enact, than remain safe and silent. We can only conclude that government, government agencies, and consumers and health care workers must be part of the disease if we all remain silent and passive bystanders and aid hospital corporations in bankrupting a system meant to ease the cost of being ill.

What you are doing here today is the beginning of what we know will be a lengthy process that eventually can change the face of health care in this country. We thank you very much.

Mr. DINGELL. Ms. Jacot, the committee thanks you very much for your assistance.

Ms. Hutchinson or Ms. McCauley, do you have any comments you would like to add at this time?

TESTIMONY OF ROBERTA D. McCAULEY

Ms. MCCAULEY. Yes, sir, I would. I would like to note that not all of the Humana hospitals in Louisville are run in the same way.

The Par-level cart is only brought to our floor once in a 24-hour period, and it is very seldom audited. As far as storing things or hauling them out of the hospital, Humana Southwest has not hauled anything out in a moving van, to my knowledge, although I do know that before Joint Commission, we have this massive clean-up campaign, emptying needle boxes the morning before JCAH comes in, so we won't get any deficiencies and so forth.

And with our care plans, we have standardized care plans which are put on patients' charts upon admission that are a prewritten—we put them on the chart with the diagnosis, initial them, and date them; and they are updated, supposedly, on a daily basis.

Mr. DINGELL. Thank you, Ms. McCauley.

Ms. Hutchinson?

TESTIMONY OF JUNE M. HUTCHINSON

Ms. HUTCHINSON. I would just like to add that, yes, all the things that Ms. Jacot has said was true—about the charges, about equipment.

I found a lot of times that the equipment, even though patients are being charged for the equipment on a day-to-day basis and the cost of the equipment—the equipment is not the most conducive as far as giving a good picture of what is actually going on with that patient.

And I am thinking particularly of some monitors that I had used at one point for some of the patients down in the back of the emergency room. They were all supposed to be patients who were on heart monitors, and the monitors we were using on them were very obsolete. You couldn't get a good reading as to what the picture really was of their heart condition at that time, yet you were expected to sit there and be responsible for anything that might happen to the patients, based on what you could see on the screens.

And I found that to be true in other areas. They had bought some blood-pressure cuffs to bring up on the units, and I found that I was going through and having to manually check some of my patients' blood pressures, which takes more time; but I found that the Dynamaps, they are called, that are used—they are automatic blood-pressure cuffs—are not always giving a true picture of what the patient's true blood pressure is; and if someone doesn't follow up and check with a manual blood pressure, a lot of time you don't get a true picture of what could be a possible problem going on with the patients.

Ms. JACOT. If I may, one of the things that concerned me, as I began to become aware of how patients are charged, was my responsibility as a nurse to at least see that, being an employee of the hospital, to see that these charges are accounted for, but it be-

comes almost physically impossible when you are as busy as you are on a floor to account for these charges. And that concerned me.

It concerned me because it forced me to have to arbitrarily pick a patient, and if I didn't arbitrarily pick a patient, somebody else would. Who that somebody is, I don't know, beyond my unit supervisor; but somehow these charges are either accounted for or swallowed, and how they swallow them, I don't know.

I am just saying that I became aware that charges are being given to patients that may not necessarily truly reflect what they did or did not use in the hospital; and I resented having to take time to try to figure this out when my job is to be caring for the patients.

Mr. DINGELL. Thank you very much. You have given us powerful testimony.

The Chair would like to make just a couple of small comments at this time before I recognize members of the committee for questions. The Chair would like to observe that it has always been the policy of this committee that we maintain a warm and friendly interest in those who testify before this committee. We like to see that they prosper and that their appearance here before the committee in no way inhibits their growth or their success or their happiness or their general levels of prosperity. We like to see to it that no action is ever taken against them because they have appeared here or because they have cooperated with the committee in terms of our inquiry.

I would like you and everybody else who might be within the sound of my voice to know that we have been singularly successful in those matters because we are singularly vigorous in seeing to it that those policies are fully and properly implemented. And I would like you to know that we maintain a very special and gentle interest in your well-being and that you suffer no difficulty by reason of your having appeared here before us.

We would like to hear from you from time to time to know that all is well, and we would maintain a special interest in finding out if at any time you are in any way given reason to feel that your success or your prosperity or your well-being might be in any way impaired because of your appearance here.

Having said those things—I am sure you understand what I have just said to you, and I hope that you will take the comfort that I can give you in having said so.

Having said those things, the Chair now recognizes my colleagues for questions, commencing with the gentleman from Oregon, Mr. Wyden.

Mr. WYDEN. Thank you. Thank you very much, Mr. Chairman.

Ms. Jacot, you lay out a very alarming and arbitrary practice of billing that ought to concern anyone who uses these services. I know that you informed Humana management of these practices. What was their response when you brought it to their attention?

Ms. JACOT. Many times, we were told just to do the best we can to find the charges, and what we couldn't find, they would take care of.

Mr. WYDEN. Did they make any attempt to justify these practices to the staff?

Your testimony talks about when you don't even have supplies on the cart, the unit ends up getting billed for it. These kinds of things, one would assume if they knew about it, they would offer some justification; but what you are testifying today is that they really didn't try to justify it and just said, well, make the best of the situation.

That's essentially what they said?

Ms. JACOT. Essentially. I think if you go with the statement, you know, it is not ours to question why, it is to do or die. And it had that kind of attitude towards it, it is not within your purview.

Mr. WYDEN. I think we all know that if you don't account for the lost charges, eventually somebody is going to have to pay for it. I guess the question next is about the patients.

Did the patients complain about getting billed for services and supplies that they never got?

Ms. JACOT. In my own experience, it wasn't a direct comment as to individual supplies or items so much as it was a generalized statement that said, considering what I paid for my bill the last time I was here, I should be owning half of this hospital, was the kind of response that I would get.

I know June and Bobbie have gotten other kinds of responses that they might be willing to——

Mr. WYDEN. That would be helpful.

Ms. MCCAULEY. Well, with my experience, the patients have received things, or they were nonexistent, or so forth, patients ask me about it. I am told to refer them to administration, accounting, or to the claims office, which I do. And I have had experience with Humana's Claims Office with an incident with my husband and my son last year, for which I am still receiving bills that Humana will not pay, although I am 100 percent covered.

Mr. WYDEN. So they weren't willing to be an advocate for patients? They just said, well, go off on down to this claims "never-never land" and see if you can make your way through that morass?

Ms. MCCAULEY. That is correct.

Mr. WYDEN. Patients got stonewalled pretty much like you all did?

Ms. MCCAULEY. Yes.

Mr. WYDEN. Now, you also paint a very disturbing picture about the Joint Commission, in effect, I gather, saying you felt the Joint Commission was due. Now, it is particularly of concern what you had to say about the nursing staff levels.

How did your staffing levels change during a Joint Commission inspection and afterwards, Ms. Jacot?

Ms. JACOT. My experience, sir, is that it is idyllic.

Mr. WYDEN. When the Joint Commission comes by?

Ms. JACOT. When the Joint Commission comes by, everything is idyllic. I have never had anything more than four or five patients assigned to me on any given day while the Joint Commission is in the hospital.

When the Joint Commission leaves, I am back up to 8, 10, sometimes 11 and 12 patients, depending upon the staffing of that day.

Mr. WYDEN. Was this fairly common knowledge around the hospital that you would have one staffing level when the Joint Com-

mission was coming through and you would have another level of staffing when things were normal?

Ms. JACOT. Yes, sir.

Mr. WYDEN. Now, when the nurses discuss these kinds of practices with Humana or management, what did Humana say about this?

Ms. MCCAULEY. I met with our administrator last spring and discussed some of these problems with him. I addressed this problem both in writing to him, I have addressed it with my nursing manager; I have been given the run-around.

"We have a certain budget to meet; this is how we have to meet it."

"We are only allotted X amount of nurses for A amount of patients." And those do not even include patients on a 23-hour-admission basis, which are on observation; they are not even counted on our census, so we are not alerted nurses for those patients, although they require a lot of care.

Mr. WYDEN. Do you want to add anything, ma'am?

Ms. HUTCHINSON. I just wanted to say that basically it is like Rita said, when Joint Commission is there, the staffing is good, things are—equipment is in good working order, things are running smoother because we have more people to do the job. When Joint Commission leaves, I am going to guess maybe 75 to 80 percent of the time we are working in conditions that are less than conducive to be able to give good patient care.

You find a lot of times you are going in, you are trying to do the best you can and take care of your patients, but there is only so much you can do when you have got one patient down the hall that may be taking an hour or two of your time and you have only got so much time in an 8-hour day.

I find that so much of the time nurses are working frustrated, and patient-care attendants are also because of the staffing conditions being like they are. And that is why I think you see a large turnover in hospitals as far as nursing. And you are seeing patients every day get less than adequate care, and this is what they are paying for.

Mr. WYDEN. My light is on, and I know my colleagues have questions.

Do you all have any reason to believe that the management knew when there was going to be an inspection, in advance? The reason I ask is, back when I was a young man, I was director of the Gray Panthers back home in Oregon. We were very involved with the nursing home situation. Back then, it seemed like the nursing homes always seemed to know when some kind of inspection effort was under way.

Do you all have reason to believe that down at Humana they knew in advance?

Ms. JACOT. When it comes to Joint Commission, it is my understanding the Joint Commission notifies the hospital in advance of their coming.

Mr. WYDEN. For all inspections?

Ms. JACOT. Well, I think they have surprise inspections, but I don't think they announce that quite as far ahead.

Mr. WYDEN. That's what I meant. I meant on the surprise inspections.

Ms. JACOT. Well, I am not really sure how that is done. I don't know the mechanism of how Joint Commission notifies them or if they do at all. But I know that the networking within the hospital, when we have one of these so-called "inspections" is such that within minutes every floor in the hospital knows that we are in a surprise inspection, and we have to stop everything we are doing in terms of patient care and get equipment, straighten things up, get-everything-squared-away kind of idea.

Mr. WYDEN. So even on the inspections that were supposed to be surprise ones, they seem to know?

Ms. JACOT. Yes.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman.

The gentleman from Georgia, Dr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman.

Well, let me ask you—I am interested in all of this preparation to get ready for an inspection and what goes on. Has the Joint Commission been told about these practices that take place and that after the inspection is over, you go back to the situation you were in before the inspection was announced?

Ms. JACOT. It is my understanding that there have been nurses that have written letters to the Joint Commission notifying them of certain infractions.

Mr. ROWLAND. Do you know what kind of responses were received back?

Ms. HUTCHINSON. Yes. I would like to address that.

I had written a letter myself to the cabinet of Humana Resources and explained to them about, they had had an investigation in the hospital where I worked. I was working at Audubon at the time. I addressed the question to them, why this happened, why the hospitals were adequately prepared well in advance that they were going to have an inspection so that they could prepare and have them staffed up, et cetera.

I have a copy of the letter in front of me. Basically, they were just saying that—I think I had written and asked them if they could have an investigation without the hospital's knowledge. It said—and they told me basically, "Since this hospital is a Joint Commission-accredited hospital, we will be unable to schedule our investigation until the Federal Department of Health and Human Services in the Atlanta regional office reviews your letter and authorizes an investigation. We appreciate your taking time to write of your concerns, and you will be advised of the results of the investigation."

Mr. ROWLAND. Did you hear anything after that?

Ms. HUTCHINSON. No. I do know that I am going to say about 3 to 6 months ago there was a surprise investigation over at Audubon, the hospital I was working in at the time, and things were rather chaotic because no one seemed to know the Joint Commission was coming that day, so things were, like Rita said, kind of crazy, because we were running around trying to get everything so it looked like we were able to give the kind of care that we needed to be giving but we didn't have enough staff to do it, so we were all run-

ning around trying to take care of getting everything cleaned up and equipment where it should be.

Mr. ROWLAND. Mr. Chairman, I would like to ask that without objection that letter and response be submitted to the subcommittee.

Mr. DINGELL. Without objection, so ordered.

Mr. ROWLAND. Have any of you ladies worked at other hospitals?

Ms. MCCAULEY. Yes.

Ms. JACOT. Yes.

Mr. ROWLAND. All of you have worked at other hospitals?

What is the situation at other hospitals relative to an inspection by the Joint Commission vis-a-vis Humana?

Ms. MCCAULEY. My experience with other hospitals is basically the same. We knew the Joint Commission was coming in, we knew well in advance, and we had plenty of time to prepare, so we would spend a lot of time doing things for nursing like doing care plans and things, but not to the extent that I have seen at Humana Southwest.

Ms. JACOT. My problem is I have worked for Humana for 17 years. Most of my experience was with Humana. The only other time that I worked in hospitals they were county or city hospitals, and I was never aware of the issues as I am now, so I can't even speak to that because I just wasn't sensitized to it at the time.

Ms. HUTCHINSON. The other hospitals I have worked at before, yes, it seems to be the general way the Joint Commission does things. They usually notify the hospitals ahead of time when they are getting ready to do an inspection, so it gives them enough time to prepare and get enough staff in.

I wanted to say back when I was going back, the inspection that we had about 3 to 6 months ago at Audubon where I was working was a State inspection, so it wasn't a Joint Commission inspection at that time, so I wanted to stand corrected with that.

Mr. ROWLAND. Do you have an opinion about the worth of the Joint Commission in inspecting hospitals?

Ms. JACOT. OK. I think a regulatory system for hospitals, and an accreditation system is good and necessary. I have no qualms with the Joint Commission. My qualm comes in what we do in order to make ourselves, quote, unquote, accepted or accredited.

For me that involves doing things that I may not have done every other day of the year. It is essentially lying, and I take issue with that because what I am doing is not reflecting what truly happens, so they do not get a true picture of what is taking place in a hospital on any given day.

Mr. ROWLAND. And once they are advised of that, there is no particular action taken as far as you know?

Ms. JACOT. Not that I am aware of.

Mr. ROWLAND. Does anybody else have a comment to make?

Ms. HUTCHINSON. My experience has been the same, and I had some problems in dealing with that also because they don't get a true picture of what goes on in the hospital every day, they don't have a true picture of what kind of care the patients are getting.

They are just looking at it from an idealistic viewpoint because that particular day the staffing was adequate and things were going well and patients did get good care.

Ms. JACOT. A point to make here is this whole idea about acuity levels. When we are staffed on a floor for any given day, we are strictly staffed according to the census, which means if I have 20 patients, I get X number of nurses, X number of LPN's, X number of unit secretaries or not unit secretary, but we are required to give them numbers according to acuity. Now, they keep those things on record, and in the book it looks wonderful when the Joint Commission comes and looks and says, yes, we are being staffed according to acuity, but in reality I am being staffed or we have been staffed according to the numbers, and this kind of deception, yes, a hospital needs its accreditation in order to be able to function, in order to make its money, but it is asking of us as nurses to flat out do something that I think is just unjust.

Mr. ROWLAND. Thank you. I see my time is up.

Mr. Chairman, maybe we ought to look into the possibility of a hearing with the Joint Commission.

Mr. DINGELL. The time of the gentleman has expired.

The Chair recognizes now the gentleman from Kansas, Mr. Slattery.

Mr. SLATTERY. Could you share any information that you have with us about interior expenditures on the hospitals that you have worked in?

For example, what we used to call FF&E, furniture, fixtures and equipment, wallpaper and those kinds of things. Tell us what you can about what Humana hospitals do in terms of their decoration in their hospitals, for example.

Ms. JACOT. In the 17 years that I worked for Humana, my recollection is that they have refurbished the hospital, I believe, twice or this is the third time, I am not exactly sure on that, but they have just gone through the whole hospital, put up new wallpaper, new carpeting, re-did the rooms, no curtains, you know, just everything.

This last time they have re-done the outside of the building, as well.

Mr. SLATTERY. There isn't anything inherently wrong in maintain a hospital in very nice conditions, but there is probably——

Ms. JACOT. No, I really appreciated the fact that when they did the—when they refurbished the hospital this time, they at least put in new windows and made sure the calking was sealed so we didn't have leaky windows.

Mr. SLATTERY. Would you like to comment?

Ms. HUTCHINSON. Yes, I would. I don't have the exact amount of money. I remember the last time that they were redoing the hospital when I worked at Audubon is in the last 6 to 8 months, it seems like there has been one floor under construction and remodeling ever since I was there.

I was there about 2½ years. I can't remember how much they quoted, $20-some, $30-odd a roll for wallpaper, carpeting, and I have no problems with the place looking nice for people to make a good impression, but the problems I have with is I feel like we are lacking on the equipment, you know, good equipment for people so that we know these people—like, for instance, the blood pressure cuffs I was talking about earlier, I went in and took a blood pressure on one of my patients. It said he had a blood pressure of 70

over 30. I went back with a manual blood pressure cuff and took it, and it was like 120 over 60. So if you have equipment that is working, I don't have any problems with, yeah, go ahead and fix the place up a little bit and get it to look a little bit better.

I feel like when it happens, I don't know how it overall affects the budget. I feel like if they are doing X number of dollars for presence-wise, they are cutting back on the budget for staffing, and the staffing is what is important to take care of the patients to see that the patients are getting adequate care.

Mr. SLATTERY. Do you have any comments you wanted to make on that?

I am just curious if you believe that the decorative type work that they have done on the hospitals, is it reasonable, is it extravagant or how would you characterize it?

Ms. JACOT. Well, we have hearsay in terms of what the rolls of wallpaper cost to put up, and someone quoted a $400 figure per sheet. To me that is a little exorbitant.

Now how true that is, I don't know. But that is what was reported to us. I wouldn't question that, either, so long as I felt that what they are doing is reasonable and that I didn't feel like, number one, like June says, equipment is being neglected or even that my pay scale is being neglected or benefits are not as adequate as they could be, so I look at it from a very personal point of view, how is it affecting me and the patient, you know. It is nice for the patient to be in a nice room, and the patients do enjoy that, but at what cost?

Mr. SLATTERY. OK. Let me just ask one other question to you all.

I am really troubled by the kind of system that we have in place in our hospitals, and I think it is clear that Humana and probably other hospitals, many other hospitals have played this game of holding down the actual room rate, shifting costs to other items that they can bill to patients. It has probably been going on for a number of years.

What advice do you have for patients that are going into the hospitals and how can they avoid this sort of situation? Is there anything that can be done from your perspective to help the patients be more knowledgeable health care buyers?

Ms. HUTCHINSON. I think that, number one, the patients need to get an itemized statement at the end of the time they have been in the hospital so they can take a look at it to see if there are items that they have a question in mind to whether they received or whether they got too many of them.

Mr. SLATTERY. Do you find that patients typically do that?

Ms. HUTCHINSON. No. I think patients have to be encouraged to have more control with their own health, with their own bodies. They need to ask more questions.

Mr. SLATTERY. In the hospitals I have been in, it has been normal procedure, certainly in the last few years, that when you leave your room, you are placed in a wheelchair, and you are sort of carted out the front door and pushed out the front door so that nobody will be sued if you slip and fall, I suppose, but I am just curious, in Humana and in the hospitals that you have worked in, what is the normal sort of modus operandi as someone is leaving their room and leaving the hospital? When do they see the bill? What procedure is followed as a matter of course that would give

patients the opportunity to see precisely what they are being asked to sign off on?

Is there a procedure that is followed that encourages patient review of the bills or not? Yes or no?

Ms. JACOT. Not that I am aware of.

Mr. SLATTERY. How is it done?

Ms. JACOT. Well, in my experience what the patient is doing upon discharge is going through the discharge office, and there they are told whether or not they have anything left over that they estimate their insurance will not cover and pay that part of the bill.

Mr. SLATTERY. Ms. McCauley, do you have something you wanted to add to that? I notice I am out of time here.

Ms. MCCAULEY. Yes. On discharge, we take our patients to the cashier. I have asked for patients that have asked for itemized statements. The cashier will tell them, we will send you one, and I have——

Mr. SLATTERY. But as a matter of course, they are not handed an itemized bill?

Ms. MCCAULEY. No.

Mr. SLATTERY. What are they handed, just a total bill and said "sign here", and if the insurance covers it, great, is that the way it is done?

Ms. JACOT. As far as we know.

Ms. HUTCHINSON. Yes.

Mr. SLATTERY. But there isn't, as a matter of course, a procedure where the patients are handed an itemized bill; is that what you are telling me?

Ms. MCCAULEY. That is correct.

Ms. HUTCHINSON. I think they have to request that.

Ms. JACOT. There have been times when billing will call the floor and say is Mr. so-and-so well enough to talk about his bill, and you have to decide is the guy personally lucid enough to know what billing is talking about, so we say OK, yes, the man is lucid, he can answer your questions, and they will come up.

What they say to them I have no idea because I am not in there listening.

Mr. SLATTERY. One last question on this. Even for those patients that do request an itemized billing, how precise is the itemization that they actually receive?

I mean, does it go in and talk about all of the examples that we have reviewed here today of tremendous charges for these items or does it just say room rate, incidentals, $200?

Does it itemize exactly what you are paying for, a bottle of rubbing alcohol and three packs of cotton balls or whatever it might be, does it break it down to show people what they are really paying for?

Ms. JACOT. Yes, it does.

Mr. SLATTERY. So when they request the itemization, they can get a complete itemization.

Ms. JACOT. Yes.

Ms. HUTCHINSON. There may be things they have a question about.

Mr. SLATTERY. What happens if the patient says, what in the world are you doing to me here, why are you asking me to pay, whether it is $84 for a bag of saline solution or whatever it might be, I mean, what happens if a patient objects?

Ms. JACOT. From my understanding, patients will call the accounting department within that particular hospital and attempt to speak to people there about their billing. Sometimes they get an answer, sometimes they don't.

The patients that have made known to us their problems have said that they have had sometimes a very difficult time getting answers to their questions.

Mr. SLATTERY. OK. I have no further questions, Mr. Chairman.

Mr. DINGELL. The time of the gentleman has expired.

Are there further questions of the witnesses?

Ladies, the Chair wants to thank you very much for your presence here, for your invaluable testimony.

The Chair would like to again remind you that we maintain a warm and friendly interest in those who appear before us. If you feel in any way that your personal fortunes are being impaired by your appearance here, we would like to know of it forthwith so that we may further interest ourselves in those matters.

The Chair thanks you. You are excused.

Mr. DINGELL. The Chair announces that the next witness is Mr. David A. Jones, Chairman, Humana, Inc., 500 West Main Street, Louisville, Ky.

Mr. Jones, we are happy to welcome you to the subcommittee.

Mr. Jones, before we recognize you, you have heard us qualifying witnesses as several witnesses appeared. The first question is, do you have any objection to testifying under oath?

Mr. JONES. No, I do not.

Mr. DINGELL. The Chair advises you that it is your right to be advised by counsel if you so choose during your appearance here. Do you desire to be advised by counsel?

Mr. JONES. No, I do not.

Mr. DINGELL. The Chair advises the copies of the rules of the committee, the rules of the subcommittee, are at the witnesses table before you to advise you of your rights and the limitations on the powers of the committee.

Mr. Jones, if you have no objection to appearing under oath, would you please raise your right hand?

[Witness sworn.]

Mr. DINGELL. Mr. Jones, you may consider yourself under oath. We are very pleased to recognize you for such statement as you choose to give us.

TESTIMONY OF DAVID A. JONES, CHAIRMAN, HUMANA INC.

Mr. JONES. Mr. Chairman, members of the subcommittee, I am David Jones, Chairman and Chief Executive Officer of Humana, Incorporated.

Mr. DINGELL. We have, without a single exception, the worst public address system and the worst loud speaker system in the Capitol or, I believe, anywhere else, so if you will pull that infernal

machine close to you and speak into it as clearly as you can, I think we may all hear what you have to say.

Mr. JONES. Thank you.

Can you hear now?

Mr. DINGELL. Yes, sir.

Mr. JONES. Thank you.

Mr. Chairman, members of the subcommittee, I am David Jones, Chairman and Chief Executive Officer of Humana, Incorporated, one of the country's largest health care companies, providing an integrated service consisting of both acute care hospitals and health benefit plans for employee groups and Medicare beneficiaries.

I would like to tell you more about our company, but let me first turn directly to the issue at hand.

You have indeed selected an important complex topic today—hospital pricing. I commend the subcommittee for addressing it and welcome this opportunity to participate.

Pricing in our industry is in a period of great flux. Our pricing, and the payment mechanisms to which it is wed, are caught between the old and the new. There are many good things emerging from this evolution. New reimbursement mechanisms are forcing hospitals to be more cost conscious. Major insurers and other groups are asserting their buying power to negotiate large discounts. Innovation is bursting out all over with consumers being offered a wealth of preferred provider organizations, health maintenance organizations, land managed care plans of every description.

But this period of transition has also created or exacerbated some vexing problems. There are serious problems in pricing and reimbursement in our industry. Changes need to be made, and some are being made. However, if the problems are not correctly and fully understood, are not kept in context, supposed solutions could make things worse. They could choke off, for instance, the solutions the market is beginning to find. The matter deserves the kind of careful, informed, and sober examination that this subcommittee will give it.

I admit, to my considerable personal dismay, and even occasional sadness and anger, this complex issue recently has been grossly distorted by television's sensationalizing lens. It is because this subcommittee in its hearings today presents to Humana and the industry the opportunity to attempt to dispel that distortion that my expression of gratitude to the subcommittee for this opportunity is genuine.

As the subcommittee knows, a reporter on a recent T.V. show picked out and held up for his viewers and to Chairman Dingell a half dozen or so individual supply items, needles, bandages, medications, and the like, from the 43,000 items that may be included on a patient's bill.

This reporter misleadingly presented multi-thousand or multi-hundred percent markups on these items, markups, note, over our simple acquisition cost.

Any normal person would react the way you did, Mr. Chairman, when presented with these markups in isolation. They are outrageous. I would think they are outrageous if I were presented with them in isolation.

But the real story is in what the reporter didn't tell Chairman Dingell and the world.

Let me highlight four of the more important of these missing facts.

First, the average markup of all the 43,000 supply items on the 77 individual hospital price lists requested by the subcommittee is only 127 percent, and the true bottom line, the percentage by which Humana's total revenues exceeded its total costs in 1990 was 6.4 percent, and in 1991, 6.4 percent.

Second, the markups on these supply and other ancillary items are high because they bear, not just their own acquisition cost, but also the great bulk of the enormous cost of a hospital, its labor force, and the care it provides, not to mention the cost of those patients who receive free care or care at below cost.

These charges are high because the basic room charges are so low and because there is no separate labor charge at all, and because of a changing mix of services, some quite miraculous, which were not even available 20 years ago.

Third, as a corollary of the above, to the extent supply charges offset lower room rates, total hospital revenues are not increased.

Fourth, Humana's hospitals are very competitive. In fact, measured by the singlemost meaningful yardstick, the average amount actually paid for a patient's stay, Humana's hospitals are often among the least expensive, even though we paid last year $240 million in taxes, taxes not paid by non-profit organizations.

Consider in isolation, some of the charges for individual supplies do appear unreasonable. But our industry doesn't sell them in isolation, and our industry does not price them in isolation. We are not a drugstore. We provide these items as part of the entirety of our patient care, and, for better or for worse, we price them and charge for them only as an internal component of the total cost of patient care. In that context, the true context, they are reasonable and cost justified.

The reason the markups on many supplies or other ancillary items are so high is because our charges on some of the most basic and important items, in particular the room rate, are low. So far that is below our costs even.

The ancillary items are bearing the cost of a hospital's immense overhead, the biggest part of which is labor, and the room rate is not. If the ancillary items were not marked up at all, the room rate would be significantly higher. But the patient's total bill, on average at least, would be the same. There is another absolutely basic fact that is easily lost in the essentialism of individual thousand percent markups.

Only a relatively small minority of patients, or their insurers, actually play the full charge amounts. For many patients, insurers or reimbursement entities such as Medicare, these charges have no relevance at all. They pay basically and simply on some kind of flat fee.

For another very large segment of a hospital's patients, their insurers have negotiated huge discounts from these charges, ranging up to 60 percent.

I do not emphasize this to denigrate in any sense the importance of the individuals and insurers represented by the ever-shrinking

full-charge paying segment. But, this fact is vital to understand not only the true extent of the problem, but also it is true nature. It is first and foremost a distributional problem—a problem of cross subsidization.

This shrinking full charge segment bears an increasingly heavy portion of the cost of hospital care rendered to other patients who do not pay their share. Medicare is among the prime examples.

Medicare DRG reimbursement has consistently failed to keep up with inflation, much less the actual increase of health care costs. The Government has effectively told the hospitals to act like a taxing authority, surcharging some to pay for the care of others.

The second basic problem, after cross subsidization, presented by the current charge system, is that it is simply too confusing.

The welter of charges produces a bill that is both daunting and difficult to anticipate or compare. This system has evolved over a long period of time. It is pervasive. No one company can change it without suffering substantial competitive harm.

Nonetheless, I think some solutions are emerging, and others can be tried, which at least, can lessen the extent of both the cross subsidization and the billing complexity problem.

In my view the best of these are market-based, focusing on moving people out of the full charge segment and into some of the other innovative and gross reimbursement or payment methods. I hope we will have an opportunity to discuss these at the hearing.

Let me give you just two examples of Humana's involvement in these efforts. The first is the Federal Government's Medicare risk program. This program saves taxpayers money by having an HMO risk contractor like Humana provide health care services to Medicare beneficiaries.

Under the program, the Government saves substantial sums by paying the HMO contractor 5 percent less than the government's estimated cost of providing Medicare benefits for each beneficiary who chooses to join the plan.

Medicare beneficiaries who join Humana's risk plan achieve far greater savings however, as Humana provides not only all mandated Medicare benefits but covers in addition prescriptions, a very expensive proposition for older people not covered by Medicare, vision care, eyeglasses and examinations.

Again, not covered by Medicare, the $100 annual part B deductible, the 20 percent copayment for part B services, all physician charges in excess of Medicare-approved levels, and the $628 hospital deductible.

All those are made available to these subscribers. Humana's premiums for this product range from zero to $50 per month, averaging $9.29 per month per beneficiary, with absolutely no bills, claims, or paperwork of any kind for the beneficiary. Simplicity at its best.

The second initiative is a public/private success story in Humana and my own hometown of Louisville, Ky. In 1982, city, county and State officials advertised nationally for bids to operate the public hospital and to provide necessary services for all its indigent patients.

Humana's innovative winning bid offered to provide all necessary hospital care to area indigents in exchange for a fixed annual

fee, set in 1983 at the same level as Government appropriations to the hospital in 1982, even though the hospital had lost about $4 million in 1982. That is, Humana's price Government in 1983 was actually about $4 million lower than Government's 1982 cost. For subsequent years, Humana's bid limited annual price increases to the lower of the percentage increase in the Consumer Price Index or Government tax revenues, thereby effectively capping this rapidly growing governmental expense.

At Humana's suggestion, a public ombudsman was empowered to mediate disputes as to the entitlement, and in 8½ years has never had to rule. Costs to the government for this innovative solution, which is as simple as it is effective, have increased by only 2.6 percent per year, for 8 years.

No bills, no claims or paperwork whatsoever for any beneficiaries.

Can any city in America match this accomplishment?

I would like to offer the subcommittee some additional, I think, vital, background and context relating to Humana and the industry.

One could surely get the wrong impression of this industry from the TV facts about easy multi-thousand-percent markups. Several times a year I read in the periodic reports of one of our industry analysts, Duff and Phelps, the phrase "tough industry marked by excess capacity." That about captures it. According to Health Care Investment Analysts of Baltimore, 1,059 of the Nation's 6,000 hospitals are in financial trouble. Operating profits on patient care are at a 10-year low, and the industry profit margin for all U.S. hospitals has been about cut in half since 1985. Hospitals, both for-profit and tax-exempt, are failing every month.

Humana is facing the same pressures as other hospitals. Our margins have been eroding year by year.

And, indeed, some of our 77 domestic hospitals are losing money. We have adopted a comprehensive strategy to attempt to survive and to maintain our ability to serve our commitments despite declining margins. Its centerpiece is integration into the insurance business. By offering our own managed-care plans we hope to increase volume at our hospitals, which will lower the unit cost for each patient served. It is essential that we maintain our ability to offer to our communities the best in cutting edge technology. That technology is extremely expensive.

Let me briefly quote from two industry analysts—on the assumption that you may believe that professionals advising clients where to put their money may be more objective than a company's chairman sitting before a congressional committee :

"Bernstein Research, April 6, 1991: 'Only the best managed, best capitalized, most focused and specialized facilities will continue to grow materially, but even they are likely to experience declining profitability in their acute care business. It is their non-acute care strategies that can allow Humana (to grow.)'"

And Duff and Phelps, May 13, 1991: "Throughout the industry, margins remain under relentless pressure due to continuing downward pressure on revenues because of government and third-party reimbursement practices. Within this tough industry marked by excess capacity, Humana has formulated and is executing a cre-

ative, successful strategy. It is Humana's goal to counterbalance low margins with increased utilization. Humana is the lowest-cost health care provider in its markets."

I, and we at Humana, firmly believe that we are part of the solution, not part of the problem. We are surely not perfect. But we and other innovators in the tax-paying segment are marshalling the energies of a free-market, for-profit economy, combining them with a personal commitment to health care excellence, to produce more efficient, more productive and better hospital care in America.

Let me quote once more from an analyst, Dain Bosworth, June 10, 1991: "Humana is singular in the health care and insurance industry in that it is developing a cost-effective delivery system that will provide a viable alternative to the health care cost crisis."

I would be remiss if I did not end my preliminary remarks by talking about quality—the quality of care we provide. In this hearing focusing on prices it would be easy to lose sight of the fact that most of the competition in the hospital industry is on quality and service, not on price.

It is, after all, on that basis that you or I would choose a hospital if we or a loved one were seriously ill, and it is on that basis that we would hope our doctor would recommend a hospital.

Humana hospitals offer a superior level of care. Our staffing is at 4.82 full-time equivalents. The national average is at a 4.50 full-time equivalents.

Here is a fact: Through June of this year the Joint Commission on Accreditation of Health Care Organizations has surveyed 581 non-Humana hospitals all doing their best to meet the standards. Of these only 22, or less than 4 percent, received commendations.

Of the 25 Humana hospitals surveyed this year, 17, or 68 percent received commendations. So, Humana hospitals in 1991 received such commendations about 17 times more often than other hospitals.

I will be glad to attempt to answer the subcommittee's questions.

Mr. DINGELL. The subcommittee thanks you for your testimony. We are going to go over to the Floor and vote.

Mr. Wyden will be back in a few minutes and reconvene.

So we will have a recess for 10 or 15 minutes and then we will reconvene very punctually.

So the committee will stand in recess for about 10 or 15 minutes.

[Brief recess.]

Mr. WYDEN [presiding]. The subcommittee will come to order.

Mr. Jones, thank you and we apologize because of the Crime Bill being on the Floor.

Let me ask you first about the Joint Commission.

Who was the vice president of the Joint Commission formerly?

Mr. JONES. I am sorry——

Mr. WYDEN. Who is the former vice president of the Joint Commission?

Mr. JONES. I am sure the Joint Commission probably has had a number of vice presidents.

Are you asking me if we employed one?

Dr. William Jesse was employed by Humana. He is the manager of our quality operations, the Humana continuous quality improve-

ment system, and was formerly a vice president of the Joint Commission.

Mr. WYDEN. Did he come to Humana directly from the Joint Commission?

Mr. JONES. I believe that he did.

Mr. WYDEN. At Humana Hospital in Huntington Beach, the staff found a particular number of orthopedic pins, the current end-of-the-month price paid by Humana was $85.

The patient charge for this item was $1,161.50

Why don't you tell the subcommittee why Humana would have a patient charge of over $1,100 for an item that cost less than $100?

Mr. JONES. Do you have something there that I could refer to?

Mr. WYDEN. We can give you a copy of the particular item.

Let us have that made available to you.

What we are talking about here is an orthopedic pin, the item number is 4406750.

Mr. JONES. Yes. I see it on here.

Thank you.

Mr. WYDEN. We have a particular supply, commonly used, of course, end-of-the-month price paid by Humana, $85, yet the patient charge was $1,161.50.

Why is it necessary that Humana charge a patient more than $1,100 for an item that costs less than $100?

Mr. JONES. We will have to look into that, Mr. Chairman.

All of the items together, the 43,000 items that make up the lists supplied to the committee, average a markup of 127 percent. We requested the committee to let us know if there were any items about which it would want information because we would be glad to look into that, which we will be glad to do.

I cannot tell you why one is priced this or that way. I can say that the average markup for all of them is 127 percent. If you look at all of the charges that go into a stay in a Humana Hospital, our average turns out to be right in the middle.

Mr. WYDEN. Humana made the point that when the subcommittee compares these end-of-the-month prices to the patient charges, it is not considering the additional cost that is involved in handling and delivery to the patient. If we were to use the orthopedic pin, does Humana believe that the price difference of $1,080 could be justified by additional handling charges?

Mr. JONES. I think when you look at most of these, you find that there are significant services associated with those. I believe the AHA had put in testimony here to the committee, at the time, that points out that aspirin costs a dime or 20 cents, but that the human activity, the time of the professionals involved in dispensing that, delivering it, administering it, and accounting for it, takes more than half an hour of professional time, meaning that the item which was charged at $2 or $7 or $8, actually has a minimum cost of $20 or more.

At my house when the GE man comes to look at the refrigerator, there is a $75 charge to drive up to the door and he charges time and materials after that.

Mr. WYDEN. We are trying to figure out whether the price difference of $1,080 can be justified by these additional handling charges. No one quarrels with taking medical supplies, and certainly there

would be requisite costs in virtually every instance in making sure that it gets to the patient. But we would be interested in knowing what you can tell us additionally that would justify what certainly seems to our constituents to be a very large difference and what these additional handling charges may be that would require a price differential of $1,080.

Mr. JONES. We will be glad to supply that information. I don't know what the information is. It could be significant services—I don't know. As I told you, on that and other items I will be glad to supply the information you request.

Mr. WYDEN. Your staff informed the subcommittee that these charges were not, in fact, cost-based at Humana, is that correct?

Mr. JONES. What we tried to in pricing our services is to recover our costs, including the profit, as a requirement of the institution, so that it can remain viable and continue in the future to provide the services that it provides today.

So the cost of the items certainly are taken in account, but if you tried to take an overhead expense, say, a nurse on the floor or my salary, and decide how to spread that over 43,000 items, I have been advised and I believe this to be true that the cost of gaining that information would be far greater than its value, particularly since arbitrary allocations would be required at every turn.

Mr. WYDEN. But again we are just trying to see if we can make sense of what I think we would all acknowledge is a complicated system. You do not operate on a cost based sense even in a global sense, do you not?

Mr. JONES. Let me see if I can explain it this way. For many years, from 1966 through October of 1983, the Medicare reimbursement system was, in fact, based on cost, and for out-patient services in hospitals it continued to be based on cost.

The Medicare system, the law and regulations that describe this system and how it is to be carried out encompass 10,000, that is one zero, comma, zero, zero, zero, pages in the Commerce Clearinghouse publication. Interpretation of those 10,000 pages encompass a further 32,000 pages in the Commerce Clearinghouse publications.

Mr. WYDEN. Let's see if we can shorten this. We are up on the DRG system, we know that that was a move away from the cost-based reimbursement. We want to make sure that as far as your private paying system prices and patient charges are not cost based at Humana.

If you could answer that again, that would be helpful.

Mr. JONES. About—somewhere around 80 percent, about 79 percent of the patients who present themselves at Humana hospitals are involved in a plan of some sort that pays a price that is not related to cost, a discounted price of some kind.

Mr. WYDEN. You have a number of Humana hospitals in Kentucky; is that correct?

Mr. JONES. We have seven hospitals in Kentucky.

Mr. WYDEN. The subcommittee looked at some of the price sheets and a number of the hospitals in Kentucky pay 77 cents for 1,000 milliliters of sodium chloride, yet their patients charges vary greatly. At Audubon, Ky., the patient charge is $10.90. At Lake Cumberland, Ky., the price is $22.89. At Louisa, Ky., the price is $39.50.

Why would a 77 cents item cost $10 at one hospital, $20 at another hospital and then close to $40 at a third hospital, all within Kentucky?

Mr. JONES. The executive directors of those hospitals have the responsibility for producing enough revenue to cover their total or aggregate costs.

They are given great flexibility in how they do that. Some apparently chose to place the price one place and some chose to place it somewhere else.

Mr. WYDEN. You have told me that a significant portion of patient charges at your hospital are not cost based. Given that, how does the hospital set its price for an item like sodium chloride?

Mr. JONES. The executive director of those hospitals know what their total cost budget is likely to be. Most costs in a hospital are fixed.

It is like an airplane taking off. It has all the expense, whether there are many or few patients in the hospital, and the executive directors of any hospital, not just Humana hospitals, have to find enough revenue to cover those costs or they don't maintain the viability.

Why they choose one item versus another item, I don't know.

I agree that the system is one that ought to be looked at. The two examples I gave of fixed price payment systems which Kaiser Permanente Foundation pioneered in the 1940's, and which serves around 7 million members, perhaps, offers us a model to have a look at, the Harvard Community Health Plan—there are several hundred of these organizations in the country today, including Humana.

I think the market is moving dramatically and quickly away from the kind of irrational pricing that you have discussed.

Mr. WYDEN. Let's go back to the question of how a hospital sets a price for an item like sodium chloride, because I am baffled with your initial answer.

Is there a formula used?

You have said your directors look around and try to figure out what their revenue needs are. If you can, tell us whether there is a formula or some process set out for how the hospital decides what it is going to price an item like sodium chloride.

Mr. JONES. I will be glad to tell you what I know about how hospitals set their prices.

Mr. WYDEN. Sodium chloride, which is one the staff looked at, we have in numbers—what we are trying to figure out is how you know about this process of setting prices. As far as I can tell, what happens there is cost and prices are completely disassociated.

It seems there is no real system for controlling costs, and I would like you to enlighten the subcommittee as to whether or not there is a formula or some process that Humana uses for setting a price for an item like sodium chloride?

Mr. JONES. I don't believe there is such a formula. The very evidence that you cite seems to indicate that there is no formula.

Mr. WYDEN. Do you just pluck it out of the winds?

Mr. JONES. No. The hospital has a staff, it has equipment, overhead expenses that any sort of business would have. It differs

mainly in being a service business, so labor is a larger component of its total costs.

The revenue that is needed to cover those costs is calculated and whoever manages a particular hospital chooses a strategy that seems to work for those conditions.

We have 77 domestic hospitals in different cities. Their managers have, as I pointed out, substantial autonomy and the—among the 43,000 items on there, I don't know how the price is set for any single one of them.

Mr. WYDEN. Does Humana put any limitations on the price that could be charged for sodium chloride?

The staff looked at some price sheets and found it was $10 one place and $20—what if somebody wanted to charge $1,000 at one of your facilities?

We share your view that this is a complicated system.

You mentioned the question of labor costs. There is no question that labor costs are a significant force of running a hospital, but we would like to know whether there is a formula you use, and if there are even any limits on the price that one of your facilities could charge for sodium chloride?

Mr. JONES. Assuming for purposes of argument that one did raise the price of that to $1,000, what he would have to do would be to lower other prices so that the total price comes out the same place.

Mr. WYDEN. Where is that written down then as part of the formula that if someone raises the price on sodium chloride that they have to lower it somewhere else, is that written down as part of a formula?

Mr. JONES. First, I am not aware of the existence of a formula, nor am I aware of the existence of a written policy on this subject.

We look at the total revenue and the total expense for the hospital. So if one thing goes up——

Mr. WYDEN. Why don't they just exceed their overall revenue goals if they choose to do it, just raise sodium chloride up to whatever ridiculously high price that comes to mind—is there something restricting them from doing that?

Mr. JONES. Yes, two restatements. First is competition.

Second is the fact that just under 80 percent of all the patients who are present at our hospitals are covered by an organization that in most cases is larger than Humana, that is highly sophisticated, that includes Medicaid and Medicare programs, that includes the largest companies, and I don't know if they look at individual prices or not.

I do know their computers look at the total amounts of money they accepted for a case-by-case type of case since you wisely instituted the DRG payment system, that has been widely copied in terms of ability of insurers better to address these kinds of issues.

But competition is always out there. If hospitals could raise their prices, Humana hospitals or others, why would we have 1,058 hospitals out of 6,000 on the distress list today?

Mr. WYDEN. Because a lot are in communities like mine, where we are shouldering an enormous amount of low-income people. We know that facilities that are in urban areas and they are treating people that have been shot up in gang shootings, and in small rural areas—we know they have problems and they are not getting

a fair shake from DRG reimbursement rates. I heard the charity physicians that were described at your facility, that one of the reasons I am asking these questions.

Let me ask you for the record to provide evidence of lower prices that would offset the very high prices. We would like to know more about this process you use for setting charges other than to say, well, the magic forces of the market are going to do it through wonderful competitive juices in the economy.

Let me ask you about one other item. At the Autubon Hospital in Louisville, there is an item, 4308505—it is an aorta valve.

The current end of the month price is $600, yet the patient charge for this item is $9,906.50. Why would someone get charged almost $10,000 for an item costing Humana $600?

Mr. JONES. Let me begin with the first two answers that I have given you before. Had you asked us these questions in advance we would have been glad to be prepared on them.

Second is that among these 43,000 items charged by 77 different hospitals, I don't know the answer to that.

In most cases, when we have looked at these things—for example, a TV program that we mentioned, a bottle was held up, Visine, or something like that, and it was pointed out that it cost 29 cents in the drug store off the shelf, that it cost $8 in the hospitals.

In fact, that item was on sale at retail in our pharmacy in a hospital in Louisville Hospital that day for 15 cents. The TV reporter got ripped off, he paid twice as much as if he had bought that at retail in our pharmacy.

When the item has to be dispensed, and delivered, and administered, and accounted for in the medical records and the financial records, the cost of a low-priced item is really very high. And my expectation is, as we look into these items, that it is describing some sort of service, it could be a mistake.

The item referred to is nothing but a clerical error.

Mr. WYDEN. I share your view that TV reporters are known from time to time to get ripped off. No quarrel with that.

But on this thing with respect to the aorta valve, is there any information that you can give us that would offer some explanation for why somebody gets charged almost $10,000 for something costing $600, which is a difference of $9,300?

Mr. JONES. As I told you——

Mr. WYDEN. Could it be a mistake?

Mr. JONES. It could be. I don't know. There are 3,000 items on those sheets.

As you ask the questions I am not likely to have the information about each of those. We will look into that and get back with the information.

Mr. WYDEN. At the San Liandro Hospital, Humana pays $2.10 for a bag of ice. The patient charge here is $35.

What can you tell us about this billing process?

Mr. JONES. My answer, Mr. Chairman, would be the same as it has been on those other specific items. We will be glad to look into it.

Mr. WYDEN. You have no awareness of special handling or specialized trays——

Mr. JONES. I was trying to think from my own experience if I had ever seen a bag of ice in a patient's room, and I have not.

Mr. WYDEN. In your statement you said that increased supply charges offset lower room rates. Are the charges for some of these things that we have been looking at, the pins and the ice being used to subsidize artificially low room rates?

Mr. JONES. First, the term "room rate" is sort of a generic term that means routine services as opposed to specific departments or specific revenue departments like the imaging department or the laboratory or the surgery, and so forth.

I checked to see what the rate of increase in the room charge was over the last few years and found that room charges have gone up by about 6.6 percent per year over the last 6 years, while the revenue from ancillary services has gone up about 9.9 percent so it has gone up at a faster rate.

I can't explain all of that but what you should look into, I know that 20 years ago we didn't have most of the things that happen in a hospital today. People are in the bed most of the time.

A room today built today doesn't look much different than one built 50 years ago. The basic services in the room haven't changed that much and the cost of the room rate has gone up by inflation, maybe slightly more.

But today we have the litotriptor, the magnetic resonance imaging, things that are miraculous that are available today that weren't available then.

It is a bit like comparing a Model A Ford, which had no fuel pump because the gasoline went down by gravity, with a new Cadillac, which many have been highly sophisticated systems.

So the products has changed rather dramatically, and, I believe, you will find that the shift from 20-80 to 80-20 is actually in the fact that the product being compared is not the same.

Mr. WYDEN. I will have additional questions.

Mr. Bliley?

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Jones, in your statement you point out that the supply and other ancillary items must bear not just their acquisition costs but also the great bulk of enormous cost of a hospital.

But isn't it true that the room rate must also bear a great bulk of the enormous cost of a hospital, and why has Humana decided that the charges for ancillary items must be marked up but that room rates must be kept low?

Mr. JONES. I was in part addressing that issue with Mr. Wyden.

The room rate hasn't gone up as fast as the other. When we came into this business in 1969, our charges were largely determined by negotiation with the Blue Cross Association, and over the years they are stronger in some places and weaker in others, but Blue Cross, I think, still has the major market share in the hospital or health insurance field, and how that came to be done in that we originally, I honestly don't know.

I know in my 22 years in the hospital business, I have never had a person call me and ask me what is the room rate or what is the rate for any other thing in the hospital.

I know some people have said that the hospital keeps the room rate low because it is the most visible. I don't know if that is correct or not.

I believe as I suggested that the change in the product mix probably has more to do with that growth in the total revenues and ancillary services than any other single factor.

We are going to study that to try to see if that is true. Most of the things that are in the ancillary arena today didn't exist 25 years ago.

Mr. BLILEY. You are the CEO and have been for some time for Humana?

Mr. JONES. Yes, for 30 years.

Mr. BLILEY. It seems to me you should know why room rates are low vis-a-vis other things. I am sure the "Courier Journal" is not too different from the "Richmond Times Dispatch" in that once a year, usually on Sunday, they will have a special analysis the hospitals in the area as to what the room rates are.

Patients can ask their doctors about it. Of course, most of the time the doctors are on the staff of a certain hospital and that is the hospital you go to. I know that, too.

But you have no way of knowing what you are going to need once you get to the hospital in the way of ancillary services, so there is no way to check that, is that right?

Mr. JONES. That is absolutely right. We do negotiate over rates vigorously and often.

We have currently between 750 and 800 separate contracts in our 77 domestic hospitals with surrogates who purchase health care for consumers.

Almost all health care is paid for through third party payors of one kind or another, so the price negotiation that goes on—and it is very vigorous, GE in Louisville a self-insured organization comes to mind, very large sophisticated purchasers of health care services negotiation with us for lower prices all the time.

Sixteen percent of the people who use our hospital system, and I imagine this is pretty typical, I don't know for sure—are covered by insurance companies that so far haven't negotiated for a discount.

The number goes down all the time because more and more insurance companies say wait a minute, why am I paying a higher price. That leaves about 4 or 5 percent of the people not covered by anybody. And I think that is a very serious problem in our country, and I have a lot of ideas how we might address that, because I think it is a travesty for a wealthy Nation like ours to have people that are not insured, because I think we can afford it, and with the $60 billion tax subsidies that currently exist and goes mainly to people like you and me and the middle class, there are a lot of people who could be insured.

Mr. BLILEY. I just came from a luncheon having to do with health care and we had an expert in who has done a study, soon to be published, and who pointed out that companies in global competition, they don't raise their prices, they tend to negotiate wages down with their employees in order to make up for increasing costs in hospital situations.

Small firms, what they do is they cut benefits, in other words, they cut benefits, which shifts the cost to the employee in most instances.

And unionized firms, it tends to be jobs, unemployment. And that is how they hold down costs.

It is not a simple problem and it wouldn't be available to a simple solution. When you come up with simple solutions generally to complex problems, they are almost universally wrong.

Is Humana all that different from any other hospital in the way it charges for rooms and in the way it charges for ancillary services?

Mr. JONES. I hear testimony from people who say that we are pretty typical, experts who have looked at that.

We are different from other hospitals in one major respect; in 1984 we recognized the problems and did something about it.

We began to integrate our services with managed-care plans which provide affordable health care to consumers.

Mr. BLILEY. Costs of operating hospitals, what percentage of your costs are administration, and how does that compare with the AHA or American Hospital Association typical hospital?

Mr. JONES. I can't tell you exactly what our overhead proportion is, although I did see a couple of days ago in preparing for this—somewhere in the total administrative and overhead costs range somewhere in 30's in percentage.

I do know specifically that we compared ourselves to all the taxpaying hospitals and all the non-taxpaying hospitals and we are lower than either one.

Mr. BLILEY. That is why you make a better profit too I would suspect.

Thank you, Mr. Chairman.

Mr. WYDEN. Thank you, Mr. Bliley.

Let's go back to the question of what the subcommittee has heard, whether or not there is a game going on to avoid charging high-visibility items such as room rates for full cost, plus profit, and that instead visible charges are being held down to fool the public and others concerning the true cost of hospital care.

How would you react to that argument, that in effect this is just really, Mr. Jones—I understand it posses by way of an argument that the subcommittee has been informed of, that this is basically a shell game to hide the charges that are truly associated with a hospital stay.

Mr. JONES. I don't think that is correct. After I heard that earlier testimony about our hospital in New Orleans having a high-visibility item in the pharmacy, I checked and found that among the 77 hospitals that sent in information on 43,000 items, that that is the only place we found where an executive used that term.

I think it shows that there is vocal autonomy and some people probably think that way. I don't think there is a shell game going on at all.

I don't see an advantage to us if the payment—first, it is covered in most cases by either negotiation with very powerful surrogates on the other side, or in the case of government by fiat, where there is a figure that we accept, period.

I don't understand the benefit to us from that sort of approach, and I don't think that is a major reason for this.

Mr. WYDEN. Let me ask you about this situation in New Orleans. Humana turned over a document—I will give you a copy—that relates to the pharmacy markup situation. The first item says high visibility and goes on to say on high-visibility items the charge is the average wholesale price, plus 10 cents, which would, of course, be a low markup rate. Yet for injections, up to $10 are charged the average wholesale price, plus $10, and for injections over $10 it is the average wholesale price times two.

So you have a situation within the pharmacy at New Orleans that they, in effect, are barely marking up the average wholesale price on a high-visibility item, while at the same time taking a $2 injection and charging $20 for it.

So it seems to me here is a pretty clear case, unless our subcommittee is just misreading this document, of a high-visibility item being kept much lower relative to less visible items. Is that a fair reading of this particular document?

Mr. JONES. First of all, can you describe one of the high-visibility items you are talking about?

Mr. WYDEN. They are listed. This is your document, pharmacy markup, high visibility, and then it goes on to talk about all the various products on the list.

Mr. JONES. I can't tell from this list that there is any product names there. There is something called high visibility, but I don't see any products listed.

Are you suggesting that the next group of things that are under the heading "pharmacy markup" are themselves high-visibility items?

Mr. WYDEN. No. It doesn't apply to it, given when you look at all these additional items that there seems to be a different markup.

Mr. JONES. I pointed out before that among the 77 hospitals, one of the administrators, perhaps, had the view that there are high-visibility items—did you find that in other cases?

Mr. WYDEN. Your contention then is that if this document is right, it would be your view that this is a very rare, unusual occurrence at Humana; is that correct?

Mr. JONES. I know that I checked and we couldn't find any other place that this kind of terminology was used.

I am not saying that it is not, but we didn't find it. I notice this page falls in line with the 127 percent markup that we mentioned that on average our prices are marked up.

Mr. WYDEN. The American Hospital Association gave the subcommittee staff data that shows the typical hospital does not recover its costs in its room rates and thus would be a loss leader.

Do Humana patient charging procedures recover the full cost of your hospital rooms or does Humana provide these rooms at a loss?

Mr. JONES. I am not sure what this is that I am looking at. Is this a Humana document or is it someone else's?

Mr. WYDEN. This is something that the American Hospital Association provided the subcommittee, and this is data that would indicate that a typical hospital, a typical hospital in this country does not recover its costs in its room rates and thus is a loss leader.

So what we wish to know is whether Humana's patient charging procedures recover the full cost of your hospital rooms or whether Humana is, in effect, providing these rooms at a loss.

Mr. JONES. Based on what we have seen already with the wide variations that occur from hospital to hospital in our system because of the local autonomy, that may differ from hospital to hospital.

My impression is that on the whole we probably won't look much different than this AHA sample of hospitals.

Mr. WYDEN. Do some of your hospitals offer rooms at a loss?

Mr. JONES. I would be glad to get that information for you.

Mr. WYDEN. I can understand your wanting to get back on some specific charge, and I shared your view on a number of questions relating to cost, such as labor, but this is a pretty important question.

The question of whether Humana has a significant number of hospital rooms that are being operated at a loss is something that isn't some kind of obscure trivial kind of question.

Are you saying that you are not aware of what that number is even approximately today?

Mr. JONES. Mr. Chairman, what I am saying is that if you take the total of the cost and charges that go into each patient who uses a Humana hospital, that our charges in the aggregate and our costs in the aggregate are quite competitive, and that our acuity index, the Medicare adjusted case mix, is about 5 percent higher for Humana than for other losses in the country, and I am having some difficulty understanding the relevance of——

Mr. WYDEN. We want to know whether your room rates cover cost.

Mr. JONES. It all depends on how you allocate the costs. The costs can be allocated in any number of ways, and as I pointed out for many years under Medicare we were on a cost-based system that has the 42,000 pages of data for those interested in knowing more about it, and the allocation of cost is subject—is a subject on which the accountants I am sure will differ.

I myself don't know a way that is affordable that is accurate that allocates the cost within a hospital to whether it should go to an ancillary department or to room and board.

Mr. WYDEN. You have told me that you can not tell me whether room rates cover cost at Humana. You have said that it depends upon the formula.

We have asked what the formula is and I cannot get anything specific as to what the formula is. I mean this seems to be a very unusual way of pricing services, Mr. Jones.

Let me ask you one other question and then I want to recognize my friend from Virginia for any additional questions he may have.

What do you say to a patient, Mr. Jones, when they pay their bill, when a man or woman comes and looks at their bill and sees that in addition to their $400 and $600 room rate, they are being charged $25 for a bag of ice, $85 for a saline solution and $70 for egg crates. What do you say to them?

Mr. JONES. In my experience they talk about what they pay. One of the cases that was on the TV program, the lady talked about a

$4,000 case and when we looked into it I think her payment was $15.

The consumers actually buy their health care coverage when they buy their health insurance. In the market we work and compete in that is where we see the concern about health care costs, and I never personally had an inquiry of the kind that you described.

Mr. WYDEN. But clearly some of the patients pay those prices; isn't that correct?

Mr. JONES. About 16 percent of patients who present themselves at Humana hospitals are covered by third-party coverage for the most part, but the insurance companies, for some reason, have not chosen to negotiate a discount with the hospital.

Another 4 to 5 percent of patients come who are not covered by anyone, and a large majority of those people don't pay anything. Some of them do pay, about 1 percent.

Mr. WYDEN. So we have close to 20 percent paying these prices?

Mr. JONES. Sixteen percent.

Mr. WYDEN. How many patients did you all have at Humana last year?

Mr. JONES. I believe our admissions were somewhere around 600,000.

Mr. WYDEN. So close to 100,000 people are being charged $25 for a bag of ice, or $85 for a saline solution, and $70 for egg crates, in addition to their $400 to $600 room rate?

Again, what do you say to those people?

I would like to see if we couldn't get some clear understanding of what is taking place here.

You have told me that room rates don't cover costs, there is an allocation formula, we don't know what that is. One hundred thousand people pay prices which certainly seem inflated.

You acknowledged it in your statement, to your credit. But what do you say to people when they ask you about these things?

Mr. JONES. First, the average markup is 127 percent. Among these 43,000 items, as I said a number of times——

Mr. WYDEN. Let's talk about people. Those are Americans that are represented by the members on this committee. We have got close to 100,000 people out of your 600,000 patient population that are paying these prices.

What do you say to those people?

Mr. JONES. They should join the Humana network of medical plans, which are highly affordable, and they wouldn't have to pay the retail prices.

The number of people paying charges, as I pointed out, is shrinking. I predict that in 5 years there won't be anybody in that category.

I don't know why some people choose to purchase indemnity insurance with its complete freedom of choice, and that includes the freedom of choice of providers to provide services and hospitals—at least we don't provide services on our own initiative.

Every service that we provide in a hospital is in response to an order from the patient's physician. I agree, I think that there is a need——

Mr. WYDEN. So the solution for right now, and again I share your interest in some of these long-term kinds of changes, but the solution is right now if you are 1 of those 100,000 people that is in this situation of buying egg crates at $70, and $25 for a bag of ice, and $85 for saline solution, the solution right now is to go out and buy another Humana product, that is what you are telling me?

Mr. JONES. If they buy one of our affordable HMO products, they will then have as a surrogate Humana, a company that knows a great deal about health care and how to provide it and they can buy it at a price likely to be much more affordable than their indemnity product.

Mr. WYDEN. Does the gentleman desire to ask questions?

Mr. BLILEY. I have a couple.

Mr. Jones, during the course of its dealings with either the Federal or State Governments, does Humana furnish HCFA or State Medicaid programs with cost information about its hospital operations?

Mr. JONES. Yes.

Mr. BLILEY. When and for what purpose would such information be furnished?

Mr. JONES. I am not entirely sure of the purposes. We are simply required to furnish information in a certain format—and by the way, I think all hospitals in the country are required to do that.

Mr. BLILEY. When you furnish this information about costs associated with Medicaid patients, is there any requirement that those costs be certified?

Mr. JONES. Yes, there is.

Mr. BLILEY. In other words, some hospital official has to certify under penalty of perjury?

Mr. JONES. That is correct.

Mr. BLILEY. Does the truth in negotiation act apply when hospitals furnish Federal and State Governments with information about hospital costs?

Mr. JONES. I am not familiar with that law, but if it applies to everybody in the country, I am sure it does.

Mr. BLILEY. If it doesn't, in your opinion, should it?

Mr. JONES. I would think the playing field should be level. If it applies to one person, it ought to apply to everybody.

Mr. BLILEY. In your statement you said that Humana plans to integrate into the insurance business. How will this integration affect cross subsidization of your hospital costs?

Mr. JONES. An organization that owns both hospitals and the insurance entity, such as Kaiser Permanente Group in California, has—perhaps, it has a distinct advantage in the sense that the next patient to use the hospital has very low incremental costs. It is like filling another seat on the airplane—the costs don't go up much, a little more fuel perhaps, but the unit cost for each person comes down.

As our insurance program expands and we are able to drive more volume through our system of fixed costs, that has the effects of lowering the unit costs for everyone who uses the facility, and that is what enables us to sell our insurance products at a competitive price.

There is a sort of cross subsidization in that. Each patient really subsidizes all the others, but to the extent that the prices charged—last year Medicare paid us on average $698 approximately per patient day in our hospital.

I believe our own insurance products produced for the hospital about $900 per patient day. So our insurance is to some extent subsidizing the Medicare patient. But there are other people whose insurance companies haven't negotiated a discount and are paying a much higher price than the $900, and they are cross subsidizing both of us.

We have about 750 to 800 separate contracts, not counting our own plan, with which we deal.

Mr. BLILEY. Thank you.

Thank you, Mr. Chairman.

Mr. WYDEN. Let me thank my colleague. There is a vote on the Floor and the subcommittee will stand in recess for 10 minutes and we appreciate your patience.

Mr. JONES. Thank you.

[Brief recess.]

Mr. WYDEN. The subcommittee will come to order.

Mr. Jones, in addition to the markups, the subcommittee received testimony earlier today that patients were charged for items that were not for them or given to them. How would you respond to that testimony?

Mr. JONES. I believe that is highly unlikely. Let me tell you about the charge system we have.

The supplies have a yellow tab that I believe was testified to by one of the nurses. It is a sticky thing. What the nurse has to do is when he or she uses the item of supply is to pull that off and stick it on the patient's chart, which is right there with the nurse at the time in almost all cases.

It is certainly true that sometimes there are emergencies, the nurse is busy doing a lot of things, and instead of immediately putting it on the patient's chart, they will stick it on their blouse or someplace like that and do it later on, and I am sure that sometimes, because of the press of business, by the time they get around to putting those down, they forget, and when that happens, what one of the nurses pointed out is there may be a lost charge that we have to swallow, but all of that is audited retrospectively.

A diligent effort is made to make sure that the charges go to the right patient, and I absolutely categorically deny that if we don't know who to put it on, that we put it on somebody. A nurse may have done that at some time, but actually the nurse doesn't make those charges, and they may not fully understand how the system works.

When those slips go back from—when those tabs go back—they go to someone that is called a unit secretary and the unit secretary or ward clerk is the one that actually does the posting of those charges.

Mr. WYDEN. Well, Mr. Jones, as I listen to you, I just get more and more curious to hear your views, and particularly I sense a very interesting dichotomy. I spent a considerable amount of time before the break trying to get you to give us any information as to whether Humana room rates were based on cost, something which

I thought was not some obscure or difficult bit of information to have.

You told me you couldn't do that. Now I ask you questions about the nurses' carts, and you have launched into quite a lengthy discussion about how practices are dealt with on nursing carts and this couldn't have happened. Now, maybe you can enlighten me on this dichotomy.

Did someone just brief you during the break on the nurse's cart situation?

Mr. JONES. No.

Mr. WYDEN. You just happen to know everything about the nurse's carts but you don't know whether room rates cover costs?

Mr. JONES. If I may, Mr. Chairman, I would like to say a word again about the costs. In dealing with supplies, if I may——

Mr. WYDEN. I would like you to answer the question first before we go off——

Mr. JONES. You asked about costs, Mr. Chairman, and that is what I am about to answer.

Mr. WYDEN. A specific kind of cost. You have told me that you couldn't tell me at Humana whether room rates were based on cost, but you can tell me quite a bit of detailed information as it relates to nurses' carts, and I am very curious about how that can be the case.

Mr. JONES. And I was about to answer you, and I will be glad to do that.

Yesterday, last night I think it was, when we finally received the witness list from the staff, we saw that some nurses were coming up to testify. Someone on my staff called our vice president of nursing and asked for a description of all of these items about how charges are done and so forth, so while I didn't find out about it at the break, I did find out about it last night.

I would not normally be an expert in that area, but I know a great deal about that right now. As to the cost on the room rate, what I testified to, Mr. Chairman, was that supplies which constitute—I think I heard someone testify earlier—about 12 percent of the hospital's revenue, I believe that is what I heard one of the experts say earlier, but it is somewhere in the 12 or 13 percent range.

There are 43,000 items that make up those supply items, and there are a lot more things that happen in the hospital besides the provision of these items of supply. What I testified to was that I knew of no cost effective way of taking those 43,000 items and all the other things that go on in a hospital and allocate those to any particular activity in the hospital.

Sure, someone could make such a system, its accuracy would be, I think, very, very low because there would be an arbitrary judgment made as to the assignment of almost all of the costs, and to spend enormous sums of money to no apparent purpose is something I don't fully understand.

I also testified to the fact that the competition in this field is at the point of purchasing health insurance, and there these people that I believe you characterized as individuals, the 100,000 individuals, the individuals actually were in the hospital but the people we are talking about who pay the bills are gigantic insurance companies. They are not individuals like you and me, and my advice to

them is they should get down and understand managed care and negotiate with hospitals and serve as better surrogates for their customers.

In fact, I have heard you talk about that earlier today, and I am strongly with you on that.

Mr. WYDEN. I don't think we will have any disagreement if we are talking about getting tough with insurance companies because they are the people, in effect, who ratify these billing practices, but you all have what is close to 100,000 people who are part of this, you know, system that gets caught up in what seem like grotesquely large markups, and we have got to be concerned with them because they are our constituents.

Now, we heard the testimony of patients being supplied with equipment such as heating pads that when delivered to the patient were found to be inoperative.

The second heating pad was ordered. In that situation the patient would be billed for both, according to the testimony that we heard this morning.

Is that kind of thing occurring at Humana?

Mr. JONES. No one is perfect, and a mistake may have been made, but it is certainly not a consistent practice, and we will be glad to look into that. By the way, I commend the nurses on calling it to the attention of management when they find a piece of equipment that doesn't work because the nurses really are the backbone of the hospital, the first line of defense. They are the people that really take care of the patients.

Mr. WYDEN. Well, you commend the nurses here today at this congressional hearing and we are glad to have you do that, but the nurses testified that when they brought these complaints to management, they were stonewalled, that management was not responsive, management was not resistant.

Now, as the president, what do you plan to do about that? Do you think there needs to be some changes made to be more responsive to company concerns?

I think it is great to have you commend them when you are here before a congressional hearing, but I asked the nurses specifically about what the response of management was, and they said that it was not at all responsive.

Mr. JONES. I didn't hear that testimony as to the broken—I believe it was a blood pressure cuff.

Mr. WYDEN. No, the question I asked you went beyond the heating pads and the other things. You have commended the nurses for speaking out about these practices, and we are glad to have you do that, but this is a congressional hearing.

Mr. JONES. You have mis-characterized my testimony. I don't like to say it quite as clearly, but what I did was commend nurses generically but particularly Humana nurses, of whom there are more than 21,000 for the kind of wonderful work they do in the hospitals, including calling to management's attention, since they are the ones who use the equipment, when a piece of equipment is malfunctioning. Management's response to that, I believe, is the same as our response to patient complaints, and that is every patient complaint that we receive, we follow through on.

If we know the person's name and how to get in touch with them and if we have made a mistake, we apologize. If there is something we can do to set it right, that is what we do. When I started this company in 1961 with $1,000, I didn't know it would employ 70,000 people today, but it didn't get here by not taking good care of our patients, I guarantee you that.

Mr. WYDEN. I am asking you now about nurses. Are the nurses off base? The nurses today said that management stonewalled them when they tried to bring these concerns to them.

Are you concerned about that?

Mr. JONES. The testimony that I heard had to do largely with the Joint Commission and there were some things——

Mr. WYDEN. They told us about billing practices. They said that when they saw these questionable billing practices, management, and they brought them to management, and management stonewalled them. They said basically, you know, nothing significant management would do.

Mr. JONES. I didn't hear anyone say "stonewall".

Mr. WYDEN. I asked them that question, and they said "yes, that was the response they got from management."

Mr. JONES. What I heard them say was that when billing questions came up, they were told to send the people down to talk to the claims department or the accounting department or someone of that sort. I heard no—I never heard the word "stonewall" used.

Mr. WYDEN. Did you hear all their testimony?

Mr. JONES. Yes.

Mr. WYDEN. I asked them specifically whether management stonewalled them on their concerns, and they said "yes".

Mr. JONES. I have no recollection of hearing that, but I can tell you this, at Humana anyone who has a grievance in our company can go through a procedure at which I am the sixth step. Any employee in our company has access to me about any practice which causes them a problem, and these problems certainly haven't been called to my attention, and I don't believe for a minute that we failed to address any problem in the hospital.

Mr. WYDEN. Are you saying that these nurses were not truthful?

They come here to testify under oath. They said they brought these problems to the attention of management, and you, unless I am missing something, are saying they didn't bring it to the attention of management.

Mr. JONES. I wasn't there, you weren't there. What I am telling you is if a nurse has a grievance or a complaint, she has access to me in the system, and it certainly hasn't been brought to my attention, and I don't believe for a moment that we failed to address questions.

I want to ask you a question. What——

Mr. WYDEN. We ask the questions from this side of the dais, Mr. Jones, but the point is, that we had nurses today say that they brought these concerns, you know, to management, and management was resistant to them, and I am curious whether you are going to make any effort to reach out to these three individuals now who have brought these kinds of concerns and follow up because you find these stories, which have been told to Congress

under oath, you find these distressing, and you want them followed up.

Mr. JONES. I am here to say to you, as I have said before, that if I am aware of anything in our company that needs fixing, believe me, I am going to do the best that I can to fix it. I also know from talking—let me tell you one more thing about how our system works.

Mr. WYDEN. Are you planning to talk to the three individuals who came here to testify under oath to determine the extent of this problem?

Are you going to do that?

Mr. JONES. I believe that two of those are not Humana employees, and I, therefore, think I have no legitimacy in talking to them. For the one who is our employee, I would urge her to speak to her supervisor, and I guarantee you if there is anything she has to suggest that can be fixed, you know, I admire her and I have nothing but admiration for her coming forward either at this time or some future time to call it to our attention and I guarantee you we will follow through on anything that is brought to our attention, but I think I must tell you how our system operates.

Nurses don't just report in the vertical line in Humana to the administration of the hospital. Humana has a system called a matrix management system and has had it for many years. We have had a vice president of nursing for more than 10 years at Humana. This is true in other departments as well, but for nursing in addition to the nurse supervisor and the associate executive director of the hospital who is a nurse, so that they can bring concerns up the line of command.

There also is a horizontal line of command, chain of command in which nurses can call to the attention of a nursing vice president at headquarters any problems about nursing practice within a hospital, so we get another good look at that problem, and the reason for that is the basic mission of Humana, which is to provide a level of care that is unexcelled both as to quality and productivity, and we believe in that, and I believe it is the reason that we have had the successes that we have had, and dissatisfied customers are no way to have a successful business.

Mr. WYDEN. Mr. Jones, our understanding of Humana's revenues for 1991 is that they were about $5 billion. Is that correct?

Mr. JONES. It is about $5.9 billion, I believe.

Mr. WYDEN. And your profits on those revenues, our understanding was about $350 million?

Mr. JONES. Slightly above that.

Mr. WYDEN. What percentage of Humana's $5 billion in revenue are generated by the kind of medical supply items that the subcommittee is discussing today?

Mr. JONES. I believe that it is about somewhere in the order of 12-to-15 percent of the hospital revenues which themselves, I believe, are about $4 billion out of the $6 billion.

Mr. WYDEN. Is it fair to say, then, that Humana generates gross revenues of $600 million in supply and ancillary items?

Mr. JONES. Including ancillary items, it is higher than that, but for supply items, yes, about that.

Mr. WYDEN. I was just saying supply items. Now, in your testimony you said these items were marked up 127 percent.

If the gross revenues of $600 million are generated based on costs that are marked up 127 percent, what that would indicate is for the $600 million in revenue, the cost is approximately $265 million, and the revenues over and above cost would be $335 million.

In effect, what you seem to get out of the data, and again, we wish to have your reaction to it because we are working from your numbers, is that certainly a substantial part of the profit being made by Humana can be traced to these supply and ancillary items. Is that correct?

Mr. JONES. No, that is not correct, Mr. Chairman, and it goes right to the complexity of the problem because about 80 percent of the purchasers of services from the hospital don't pay charges, there is no relationship at all to either the gross charges or the net charges and the profitability of the company.

That reminds me a little bit of a fellow we had one time that was in charge of purchasing for Humana, and every year he used to write a memo in which he showed how much money he would save through the careful and excellent management of the purchasing department.

It typically turned out to be about 200 percent of the profits of the company. He did a pretty good job, but he didn't account for two times the profit of the company, and those supply items don't come anywhere close to producing at all or half of the profits of the company.

Mr. WYDEN. They don't produce—the supply and ancillary items don't produce half of the profits at Humana?

Mr. JONES. When you add the ancillary items——

Mr. WYDEN. Let's go one at a time.

What is your—again, just an approximation. What is your calculation of what percentage the supply items contribute to Humana's profits?

Mr. JONES. I don't know, and we don't have a system that will produce the answer that you request. It goes back to what I said about trying to allocate costs among these 43,000 items. The cost of doing that would overwhelm any conceivable value from that system, and we don't have such a system.

Mr. WYDEN. So this is no system for determining what supply items contribute to Humana's profits. I gather that is also correct of the ancillary items?

Mr. JONES. Depending on how costs are allocated, that is cost for something other than the supply item itself, one can make any one of a number of or different kinds of arbitrary allocations of cost and perhaps make an approximation, but the approximation will be no better than the assumptions on which the cost allocation are based.

Mr. WYDEN. So we have to conclude also with ancillary items that there really isn't anything specific you can tell us in terms of what they would contribute to profits?

Mr. JONES. I, myself, cannot tell you that. We do have experts who have been——

Mr. WYDEN. We will hold the record open, and if you can give us any information on either the supply question or the question of

the ancillary items and what they would specifically contribute to the profits, we would find that helpful and we will hold the record open.

Mr. JONES. What I was going to say in response to that first—thank you. We do have in our organization 25 years of experience in working with the Medicare program, and using the Medicare methodology for allocation of costs, we may be able to give you an answer to those questions because we have been involved with the cost allocation.

I am not going to be responsible for the accuracy of those cost allocations or whether they are the best cost allocations that might be made, but from the Medicare cost reports, we will be glad to have a look and see if there is something we can add to your knowledge on this point.

Mr. WYDEN. Now, you say in your testimony that the Government has effectively told the hospitals to act like a taxing authority, surcharging some to pay for the care of others. I am not aware of where the Government told hospitals to act like a taxing authority.

Mr. JONES. The impression that I have after 30 years in this industry is that when the government sets a price, as it has done with the DRG payment system, and since it is an institution or at last in the last 5 or 6 years you have allocated or appropriated about 3 percent or 3.2 percent, I believe, is the best number that I have in new funds year-by-year to pay for the services provided to Medicare patients.

During those same 5 or 6 years, the population of our country has grown and with it the population of over 65, that is Medicare beneficiaries, and there is an aging of the population along with the growth of the population, and during that period of time new services and more intense use of existing services has occurred in addition to salary increases for health care professionals because of shortages, because of working at night and on Christmastime, all those things together have led to cost increases that are about 2.5 times as great as Medicare has reimbursed the hospitals during those years.

At that point, hospitals have the following choices: they can go out of business, they can begin to ration, they can lay off people or they can try to shift those unreimbursed costs, that is, the cost of caring for government-mandated patients, patients who have been chosen or selected as beneficiaries of government programs, Medicare and Medicaid, as well.

What hospitals, in fact, do and what I believe the policy of that Nation to be to require us to do is to shift those costs to other people. Some people call it the Robin Hood system, but in any event, if we are to recover costs that are not paid by Medicare, the way that is done is to charge other people who are not sponsored by the Government for that.

Sometimes it is called a sick tax. It has been around for along time, but it is especially acute in the last several years. Whether you see us that way or not, we absolutely see ourselves as a collector of taxes from other people, we are not called a tax collector, but we collect from other people to support the Medicare and Medicaid people whose costs are fully paid by Government.

Mr. WYDEN. We are only interested in this statement because we are puzzled about how if you don't know what your costs are by supplies and equipment and services how you can make the assertion that you are losing money on any given payer that pays for DRG's discounts or some other method.

All of this, at some point, Mr. Jones, has got to hang together, and what you have told us is that there are no formulas, you can't tell us what your costs are by supplies and equipment, but at the same time you tell us you are losing money on a given payer for DRG's or discounts or some other method.

How can you make that assertion if you don't know what your costs are in these key areas?

Mr. JONES. It hangs together very well.

Let me go through it for you again.

When Medicare shifted from cost-based reimbursement to DRG-based reimbursement, the assertion by government, and I believe it was generally true, is that the first year's DRG payment was based on the cost at that point, so when there was a shift made from cost as allocated by the Medicare program, the Medicare program has a methodology for determining cost, and it is Government's assertion that hospitals were paid those costs.

We moved to a DRG system, and during the years of the DRG system, assuming that the Government's assertion is correct and that we did start off the first year with a price that was equal to our cost and the prices paid by Government have gone up in the aggregate, not per person, by a total of about 3.2 percent per year while the costs associated with the care of those patients has gone up about 7.5 percent or a little more or about 2.5 times as fast.

That is the testimony that I have given, and I give it again, and I will give it again and again because those are the facts.

Mr. WYDEN. Well, you say that you have to act like a taxing authority, and taxing authorities in this country are required to use specific rules and procedures. What procedures and rules do you follow when, to use your own words, you go out and tax patients?

Mr. JONES. What I have used is an analogy.

Mr. WYDEN. No, Mr. Jones, you have said you effectively tax people. Now, there are rules in this country for taxing people, and we have constantly tried this morning and this afternoon to get some information about what rules and procedures that you use before you stick it to the patients again, and I am going to ask once more if you can give us anything that relates to procedures and rules that you follow when, in your own words, you go out and tax the patients.

Mr. JONES. What I have testified to and which I will continue to testify to is that we know what our costs are, and we seek to achieve revenues that cover all of our costs, including the cost of profit. Profit really is a cost. It is never an end. It is always a requirement. That is the cost of viability, of staying in business, of providing in the future the services we provide today, including the new technology that becomes available to take care of people, and what we try to do is collect enough money from the totality of the people who use the hospital to cover those costs.

Mr. WYDEN. Who is targeted for this tax? I am sure that your patients are going to be particularly interested in knowing that

you are effectively running a tax program here, and I think that they would be interested in knowing which ones of them are being taxed.

Mr. JONES. The shortfalls of the Medicare and Medicaid programs compared to the cost increases since the DRG system was instituted are passed along to the ever-shrinking group of charge-paying patients.

As I have pointed out, basically they are not patients, what they are is large insurance companies or large employers who for whatever reason have chosen not to take a serious interest in their own costs.

Mr. WYDEN. Well, name one. Can you name anyone that would be effectively targetted specifically by this tax program you are running there?

Mr. JONES. I would say Metropolitan Life Insurance Company is an example of an insurance company that may or may not have negotiated with hospitals for discounts.

Mr. WYDEN. Name one who has not, let us say.

Mr. JONES. Who has not what?

Mr. WYDEN. Negotiated a discount.

Mr. JONES. I just named one. In some cities, in some cases, Metropolitan Life Insurance Company.

Mr. WYDEN. You said they may or may not have. Can you name one that has not negotiated a discount?

Mr. JONES. I could certainly find for you a list of insurance companies that have not negotiated a discount. I don't know one offhand, but I can name a lot who have negotiated discounts, and I know there are lots and lots of insurance companies.

Mr. WYDEN. The fiscal year for Humana ended, as we understand it, August 31. What was the profit picture that was reported for fiscal year 1990?

Mr. JONES. For 1990?

Mr. WYDEN. I am sorry, excuse me, for fiscal year 1991.

Mr. JONES. It was as you described a few minutes ago, it was a little over $350 million, I believe $351 or $355 million.

Mr. WYDEN. Did you report a 15 percent increase in profit from fiscal year 1990?

Mr. JONES. I would say it was in the range of 13 or 14 or 15 percent. I am not sure.

It was a double-digit number. It certainly was not greater than 15, but that is the range.

Mr. WYDEN. Is that a record profit for Humana?

Mr. JONES. The $350-plus million is a record profit, yes.

Mr. WYDEN. Mr. Jones, you have been patient. I have to tell you that, you know, it seems to me what you are doing is making an enormously effective case for those who want to go to a single-payer health system in this country because if you can't give us information about basic costs and supplies and if you can't tell us, you know, basic information about room rates, I mean, these are the kinds of things that our constituents want.

We understand that the health care system is extraordinarily complicated, and I came in here for one saying that I think the heart of the problem was that the private insurance companies have simply ratified these kinds of questionable billing practices,

and I gather that you have some sympathy for that point of view, as well, but given the fact that you can give us so little information about the procedures and the rules and the formulas that you use specifically when, in your own words, you are running a tax program for your patients, I think is not acceptable, so we are going to hold the record open because I know a number of our witnesses have additional information that they would like to add.

The subcommittee has the Inspector General and the General Accounting Office conducting a number of audits for us. These audits are going to be performed at a number of hospitals, not just at Humana, but they are going to be trying to assess a cross section of facilities for private hospitals, teaching hospitals, and others.

We presume that we can count on the continued cooperation of Humana and your colleagues' in the subcommittee work, and let me just give you an opportunity to answer that.

Can we continue to count on your cooperation?

Mr. JONES. You certainly may.

Mr. WYDEN. Let me recognize the minority counsel for any additional questions he may want to ask.

Mr. WILSON. Thank you, Mr. Chairman.

I would like to follow up just a little bit on the Joint Commission on Accreditation.

Are you familiar with the way that they conduct their inspections?

Mr. JONES. I know a little bit about it.

Mr. WILSON. Is it characterized—let me ask this. Do they conduct no-notice inspections where they literally show up at the door and say it is the Joint Commission on Accreditation, we are here to take a look at your operations.

Mr. JONES. I don't think so.

The PRO inspections are unannounced and the State licensure inspections are unannounced, but I have never heard of a Joint Commission inspection at any hospital that wasn't announced.

I am not saying they don't do it, but I am not aware of it.

Mr. WILSON. Has Humana ever volunteered to submit the no-notice inspections to demonstrate your operation from the Joint Commission on Accreditation.

Mr. JONES. I don't know that that has ever been discussed one way or another with them. What I do know is when they do come in and inspect, they are quite aware of the fact that hospitals are awaiting them and that hospitals do the best they can to be prepared for them, and that is why their inspections go back and cover the last 12 months or 24 months or 36 months, and they look at the staffing records over the entire period of time because it would be pretty simple on their part to be misled by a flurry of activity at a particular point in time.

They look at the medical records, today they look at outcomes, they look at all of those things that they look at over an extended period of time and not just on a particular day.

I think that an impression might have been created that they come in and inspect and only considerations that they find at that particular period of time, but their inspections actually cover the full period of time from the last inspection.

Mr. WILSON. But, of course, that review is largely a paper review, is it not?

Mr. JONES. That was true in the past, but it is certainly not true today. It is a very, very rigorous review, and we will send you information on precisely what that encompasses because I think it will surprise you at how rigorous it is.

Mr. WILSON. Do they do interviews with people like the nurses that we have heard from?

Mr. JONES. I am sure they do interviews with nurses, and I believe they look at all aspects of the hospital's operation.

Mr. WILSON. Does Humana have a guide to administrators facing an inspection? Or you called them executive something or other.

Mr. JONES. Executive director administrator.

Mr. WILSON. That are facing an inspection by the Joint Commission on how to prepare for the inspection?

Mr. JONES. I know that we do everything possible that we can to be fully prepared and to do as well as we can on the inspection. That shows up in the grades.

The average grade this year was 80.4 percent. For Humana hospitals, it was 93.7 percent.

Mr. WILSON. Do you have a written guide that your executives can refer to when they are facing an inspection on how to prepare for the Joint Commission on Accreditation inspection.

Mr. JONES. We will supply to you whatever we have. I am sure we have a lot of information on how to prepare for that.

Mr. WILSON. So you think this is some sort of written guidance that is provided like a manual, we just got the Joint Commission's letter, here is what to do next, Mr. Executive Administrator?

Mr. JONES. I will be very surprised if we don't have significant information and help for our executive directors to do the best that we can on that, just as we do—we try to do the best job we can all the time because that is the mission of our company to have unexcelled productivity and unexcelled quality, in both cases measurable, and what they do is come in and measure.

Mr. WILSON. You mentioned a couple of other organizations that you know do no-notice inspections. What were those two organizations?

Mr. JONES. One is the PRO, that is the Professional Review Organization, and the other is the State Licensure Inspection.

Mr. WILSON. OK. Now, you mentioned in your testimony the commendations that you had received from the Joint Commission on Accreditation. What has been the nature of the review or ratings or whatever by this PRO and the State Licensure Board?

Mr. JONES. We have never failed to gain licensure, we have never failed to gain approval by the PRO board.

Mr. WILSON. OK. Do they do comments of some kind?

Granted, you kept your license, granted you kept your approval, do they do comments, do the Commission on Accreditation that gives commendations, have you ever gotten a commendation by the State Licensure Board or the PRO or have you ever gotten a derogatory statement by either of those organizations that do no-notice inspections?

Mr. JONES. First, the Joint Commission is the major organization for the accreditation of hospitals, and I don't know what the cur-

rent status is, but for many years their inspections were used by State Licensure and PRO organizations, so in many cases it is the same inspection, but I think that all the inspections do result——

Mr. WILSON. It is the same noticed inspection?

Mr. JONES. In the past, I said. Now, it is my impression, I don't know, I have never seen one of these reports of either the Joint Commission or the PRO or the State licensure. I have never managed a hospital. It is my impression that there are written reports of these inspections.

Mr. WILSON. You are chairman of the board and you have never reviewed any report by the joint commission on accreditation or the PRO or the State licensure board and you are not even sure whether the PRO or licensure board issues reports?

Mr. JONES. Our 70,000 employees are like the 43,000 items of supply. My task as chief executive officer is not to review all the paperwork that goes on in the company any more than it is to know the price of 43,000 items. My job is to lead the organization, make sure we have good strategies and good people in place and it is true that none of these pieces of paper ever have come into my hands.

Mr. WILSON. My question was not whether you have read all of them.

Mr. JONES. I testified that I have no read any of them.

Mr. WILSON. I have no further questions.

Mr. WYDEN. Let me thank Minority Counsel. The gentleman from Kansas.

Mr. SLATTERY. Thank you, Mr. Chairman. First, let me apologize for not being able to be here for more of this hearing today.

Mr. Jones, I would like to focus on how do we correct this system and what recommendations you might have. Perhaps you have gone over this earlier, but it seems to me that we have a fundamental question here about truthfulness in advertising and billing.

It seems to me it is important for health care consumers in this country to be able to quickly ascertain what their costs will be when they are going into a hospital and when they are going to come out of a hospital.

I doesn't make sense for us to try to keep the cost of a hospital room under control and then allow hospitals to shuffle over the costs of opening a facility to all these ancillary items.

Do we have to raise the cost of the rooms 10 or 15 percent to cover some of these things? Isn't that a more honest way than this scam of charging people $100 for a pair of crutches or $30 for a bag of ice?

Mr. JONES. I am really pleased that you asked about what I think ought to be done about it. Bear with me, because there are two or three things I think ought to be considered.

A few years ago, to confront this problem in the Medicare program, the government, I believe, wisely moved away from a cost-based system of looking at thousands of items. I pointed out it created 42,000 pages of law, regulations and commentary in the services.

By going to a fixed price system, which the Federal Government has done, they have made all of that irrelevant. But interestingly and for reasons that are not entirely clear to me, the government

has not abandoned the cost accounting requirements and cost finding requirements of the system.

That is, we must still carry out the dictates of the 42,000 pages even though the government is paying us a flat price. We are bemused and mystified and enormous costs are incurred in a system that produces no tangible result. We get paid a flat fee when a Medicare patient enters the hospital, yet we have to do all this bookkeeping and accounting that dramatically raises the cost.

I think the Federal Government made a good move in moving to a fixed priced. That is what the insurance companies are doing. This is going on in the marketplace and every year fewer and fewer people are choosing to stay in the old expensive system of indemnity insurance.

I predict that in 5 years, there won't be anybody left in that system. Why would anybody stay in that system when they could join Kaiser or Harvard Health Plan or Humana that is a big buying cooperative. We use our buying power to buy these things at wholesale and bubble them up and sell them to customers at a lower price.

If I were you, I would consider looking to see if there are any barriers to the consideration of competitive managed care systems. I described how we solved this problem in Louisville, Ky., where I live, about all the people who don't have insurance.

The government pays us a flat fee. Nobody knows how many indigents there are in any particular city. But we are a metropolitan area of a million people. We collect about $23 a year from the city, State and county and we take care of all the people who are not otherwise cared for.

You know how much accounting there is for that? Every month we get 1/12 of that amount. Nobody has bills to pay, we don't have to keep those tremendous records and systems that move towards simplicity and total payment for either an individual or a group of individuals, I believe, is the way to go.

Mr. SLATTERY. I appreciate what you are saying. I have asked the American Hospital Association on not one, but two instances to provide me with data about what we can specifically do to reduce this terrible paperwork burden that I hear so many complain about and I haven't heard much specific recommendations from them.

I have made that request, and I am looking forward to getting the specific response about what kind of regulations can and should be changed to reduce in a sensible way the paperwork requirements.

But getting back to the question that I am more interested in, specifically how we get away from this terrible situation we have where we are telling people that we are controlling the cost of the rooms, but we are charging you for ice and everything that you might use while you are in that room, what is the best way to deal with that from your perspective?

I understand that the system has been structured in such a way as basically pressure businessmen like you to do exactly what you have done. I understand that. I am saying how do we change the system to prevent that from happening so that people can, in fact, make knowledgeable decisions about what it is going to cost, whether you are the insure provider or an HMO.

That is doing business you or whether you are a consumer trying to figure out where is the best deal for health care. How do we change it specifically on the question that we are talking about?

Mr. JONES. I suppose you could ask all hospitals at the same moment to change their system so no one would be competitively disadvantaged and say to everybody you have to put more of your charges on the room rate and less on supplies and ancillaries, but I am not sure where it would lead you.

The whole system produces only about a 2.5 percent profit for all the hospitals in the country. I believe I heard testimony that said that for taxpaying hospitals, it was less than that, 1 to 2 percent. You could do that.

Mr. SLATTERY. What would be wrong with just requiring that all hospitals would have to put these ancillary costs on their room rate, because as a practical matter you are competing with somebody across town with the same kinds of ancillary costs that you would have. They are going to have to deal with them in the same way.

If we say to the hospitals, you are going to have to deal with all these ancillary costs and plug these back into your room rates and bill it out that way—what would be wrong with doing that? Would that not be the best way to do it without getting into a pricing structure or limits on the individual ancillary items?

Mr. JONES. That would be one way. But not everyone that comes into the hospital receives the same kinds of services. For example, a person who has a pacemaker implanted, if you charged all the people who didn't have a pacemaker for the person who did have a pacemaker through the room rate, then you wouldn't be able to distinguish between the person who might have a $5,000 pacemaker inserted while somebody else didn't have that.

Also, it might fall disproportionately on the younger, healthier, less sick patients such as young people having babies.

Mr. SLATTERY. If it is impossible to do it that way, what would be wrong with saying that you would be limited in what you could increase the costs by X percent, you could increase the cost by 10 percent over your cost, what you paid for something, across the country all hospitals will be able to collect 10 percent more than what they paid for all ancillary items?

Mr. JONES. What hospitals would do then would be the way your auto dealer does. If you go in to get your car fixed—I saw a bill on a Honda, not mine, I have a Ford Explorer—the Honda bill showed the fact that there was a charge for parts and labor, which hospitals don't do.

First, you would see a charge for labor. But on the back of it, it had 15 or 16 little cartoons and each cartoon illustrated a part of the cost that was included in those charges for parts and labor. They had broken it down a little further than hospitals do, but not nearly as far as they could have.

There are many things that go into that. In a hospital, there is malpractice insurance, a tremendous cost.

Mr. SLATTERY. I understand. If all hospitals were told that with respect to ancillary items purchased by the hospital, if they could mark them up 10 percent above their costs, all hospitals would be competing on the same playing field. If you can provide health care

to the residents of Johnson County, Kans. where you have a profitable facility making sense to you operating under that system, your competitors would be under the same system.

And then you would be competing over the delivery of health care and not over the delivery of ice and crutches and cotton balls and diapers and any other things that might be involved.

Let's structure the marketplace to the extent that there is a market in a way that is sensible, that is a realistic comparison of what people are buying. Do you understand what I am saying?

Mr. JONES. Yes. If you are suggesting that it be applied to all items of cost in the hospital, that was a system that Medicare used from 1966 to 1983. They found that it is a little bit like having your salary set at the end of the year based on how much money you spent during the year.

If you paid us on a cost plus basis or say you paid your employees on the basis of how much money they could spend during the year, their life styles would vastly improve. You almost can't think of a more expensive system than that.

A cost plus system I don't think is the right way to go.

Mr. SLATTERY. Maybe we should say there will be no write-up, you won't be able to pass on costs other than what you pay for it. In the old system, the cost plus system, I agree it was unworkable and phenomenally stupid and that is part of the reason we are in the mess we are in today.

That is history, because we changed that with the DRG. I am talking about items you have to buy in the running of this hospital, I am talking——

Mr. JONES. Then the hospital would put in a labor charge and a charge for all the departments for which it doesn't currently have a charge. Whether that would be better or worse, I don't know. It certainly could be looked at. I predict that in 5 years, nobody will be paying these charges anyway, so I am not sure——

Mr. SLATTERY. When I look over the information provided from the American Hospital Association of a typical hospital operation, it is interesting, because when you look at the cost of drugs, they estimate—and I don't know the size of the hospital—that the cost of drugs is $1.8 million, but the charges for those drugs in the hospitals is $6.4 million.

And they estimate that on EKG's—that is a real profit center, particularly because the cost is $232,000 and the charge is $1,093,000. And you can look at other expenses here, other ancillary is about a 300 percent markup also.

It seems to me—another item is laboratory expenses. That is a dramatic costs, $2.8 million. The charge is $7.2 million. And then in the case of radiology, there is an enormous markup there, too, a $2.9 million cost for a typical hospital, a $6 million charge. So it is 100 percent markup there.

It seems to me that we need to focus on some of these sort of profit centers within the hospital and bill out accordingly. The closer we can get to a situation where you can compare one room rate with another and get away from all this sort of under-the-table type billing—I hate to use that term, but that is sort of what it is—it seems we can move toward more honest operation out there that everybody can understand better, don't you agree?

Mr. JONES. I agree that we ought to have an honest operation, and we run one. This is missing something. It shows $30 million of costs and $50 million worth of charges, but we have heard testimony that the profit margins of the hospitals are under 2 percent for taxpaying hospitals and 2.5 percent for all hospitals.

What is missing is all the departments in the hospital that don't generate any revenues.

Mr. SLATTERY. And get service?

Mr. JONES. That doesn't seems to be here.

Mr. SLATTERY. I don't know how they arrived at the cost, but I find it interesting that there are some enormous write-ups in some of these items.

Mr. JONES. At the end of the day, if these are net revenues, it means that other departments that don't have revenues aren't included in the cost side of this equation because at the end of the day, the average hospital is not going to make $20 million on this batch of services, but 2.5 percent of the $50 million here—any other way of allocating costs, charges, prices that you all come up with that hospitals—that will make this a more understandable and in any way fairer——

Mr. SLATTERY. Let's go back to the first question I asked and then we can wrap this up. What would be wrong with having a rule just nationwide that we are not going to get into this business of shifting the cost of the room to drugs or shifting the cost of the room to ice or whatever it may be?

Why couldn't we have in place a system that would basically say to a hospital, to you administrators, that you can buy this stuff and bill it on to your customer, but you are going to be limited to an increase of 10 percent over your costs.

It would cause a lot of heartburn internally and we would eliminate the kind of problems described today and we would probably force up the cost of a room, but at least we would be more honest in terms of what was going on in the hospital so people could get a clear handle on exactly what health care costs.

Take the hospitals out of the business of making money on the delivery of ice, and crutches, and cotton balls, and everything else that we have talked about here today—what would be wrong with that?

Mr. JONES. It would certainly cause me no distress.

Mr. SLATTERY. Would you support that sort of a change for all hospitals?

Mr. JONES. I would want to make sure that it had purpose. If the bill that is paid by whoever pays the bill doesn't change, it is still not clear how rearranging the pieces that make it up help a consumer or anybody. I am really confused by this whole hearing, because since you—at the end of the day, the hospitals make a profit about 2.5 percent. if you move the charge from one part of the bill to another, but the total doesn't change, I think that is what we have been talking about all day, and if I support it, to me it is a matter of indifference.

Mr. SLATTERY. The point is that it is a matter of honesty, a matter of helping the public that is buying health care and helping insurance companies that are indirectly paying for it understand what they are paying for, so when people go to the hospital and

check out, after they have a baby in the hospital, they are not billed $35 for a bag of diapers as they are walking out the front door and the insurance companies have to pay for it.

I am suggesting that it would make a lot more sense to have that built in in a sensible way so that if you have to raise the room rate raise the room rate, so at least people understand what they are paying for.

The way it is now, when they look at what should be a room cost, they are not getting an accurate reflection of the cost of that room because of the other expenses they are going to incur before they leave your hospitals.

I don't mean to pick on Humana, because I understand this probably goes on in every hospital in America, and we need to acknowledge that.

Mr. JONES. The way we have dealt—I know the problem that you are concerned about, the consumer who can't figure out what is going on.

Mr. SLATTERY. I have experienced this. I checked out and I demanded my bill and I looked over the bill and here we had $25 for diapers, outrageous expenses for other little items that I questioned.

Mr. JONES. We have five children and I have been through that too. Let me tell you how we have dealt with a consumer who can't figure out what is going on, the kind of thing I think can help.

A lot of people who are uninsured are young people and they have babies and that is a real problem when that occurs. In Louisville, where I live, the way we have addressed that problem is to say that if you are uninsured and you are going to have a baby, we will deliver the baby for a flat price of $1,000.

That covers all the prenatal care and 24 hours in the hospital after that. If you want to stay over for a second 24 hours, $200 flat, no charges for anything else. It is a wonderfully popular program among the young people who aren't otherwise insured.

I think a lot of things like that can and ought to be done and we as an insurer and also as a hospital operator do those things. Anything that you come up with that makes this simpler to understand, I will support it.

Mr. SLATTERY. Thank you. I thank the chairman.

Mr. WYDEN. I think we may have one last question we need for the record from the Majority staff.

Mr. CHAFIN. Mr. Jones, you keep saying it doesn't matter where the costs are, but 10 minutes ago you said that if we stopped the world and everybody switched to charging it to the room, we could do that, but that if one hospital tried to do that, it would be, to use your words, disadvantaged competitively. There is a disadvantage if Humana took the revenues they are generating with these high-priced supply items and put it with the room rate, if your room rate became $1,200 tomorrow, while everyone else in Louisville was still at $400, you would be disadvantaged competitively, wouldn't you?

Mr. JONES. Yes.

Mr. CHAFIN. That's the point you made, the point that as long as the patient's bill doesn't change, there is no harm, but in reality it

is very important to you competing against your competitors that you put these charges off into the areas that are less visible.

You just said it—if you took the same charges, raised the room rate, but lowered the supplies, you would be hurt.

Mr. JONES. Unless all the others did it at the same time. The other hospitals in Louisville wouldn't end up with a $400 price. Since prices on average are lower than our competitors in Louisville, as long as everybody changed at the same time—if we had a $1,200 room rate, they would have a $1,300 room rate. That will be fine with me.

Mr. CHAFIN. You asked what was the point of the hearing and that is the point—that we have taken the charges that should be for the rooms and put them into the supplies where they are less visible, because if you took the cost and put it on the room, you would be disadvantaged competitively.

So you are playing the game that the entire industry is playing. Putting them in the supplies.

Mr. JONES. All I said was that when we came into the industry, that is the way the pricing was. And I told you the percentage by which the room rates have gone up compared to the percentage of ancillaries, I have suggested that you look into the possibility that that increase in ancillary might be because of more things being done that weren't done before.

At the end of the day, if the rearranging doesn't change what the person making the bill pays, I am still not sure how anyone is advantaged by that.

Mr. CHAFIN. If you would raise your room rates tomorrow and lowered your supply costs, you would lose patients if everyone else held this the way the industry is pricing currently.

Mr. JONES. I agree that any change only done by one hospital would put them at a competitive disadvantage—I agree with that.

Mr. CHAFIN. No one is saying you invented this. That is what the industry is doing.

Mr. WYDEN. Let me say that this hearing has to end because this chairman is called over to the Capitol.

Mr. Jones, I think you can see that members on both sides of the aisle have considerable concern about these issues and what I have found most puzzling about this whole discussion is the absence of any clear guidelines, procedures, rules, formulas for making these kind of decisions in what is admittedly a very complicated kind of system.

We are going to hold the record open to have you give us the additional information that the staff asked, but you should know that when Members of Congress read, for example, that you are running a tax program for our constituents, and there may be 100,000 people involved, we are going to ask that you at the least enlighten us as to what are the rules and the procedures and the formulas that you employ when you run that tax program.

So this has been a very valuable hearing. Let me recognize you, if you would like to add anything in addition. We appreciate you assertion that you will continue to cooperate with the subcommittee. And I know we are going to be in contact with you and other facilities around the country.

Is there anything you would like to add further?

Mr. JONES. Only that it has been a pleasure to be here. I appreciate your patience. I mean to tell you how the world looks to me and we will be glad to answer any request. I want to compliment your staff. I believe Mr. Chafin has been as fair-minded and even handed as anybody could be.

Thank you.

Mr. WYDEN. We appreciate that and the subcommittee is adjourned.

[Whereupon, at 3:10 p.m., the subcommittee adjourned.]

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